CAMBRIDGE

Cambridge University Press
978-1-107-02232-4 - Essentials of Global Mental Health
Edited by Samuel O. Okpaku
Excerpt
More information

Section 1 History and background of global mental health

Chapter 1

History of global mental health

Samuel O. Okpaku and Sanchita Biswas

Introduction and background

In this chapter, we will attempt to trace the origin and background of modern global mental health and sketch its domain. The history of mental health is punctuated with various movements. These have included the psychoanalytic, the behavioral, the self-help, and the community movements. These movements have been sustained over time and have merged into theory and practice. The less influential movements with shorter half-lives have been eclipsed. In the last decade we have witnessed a surge of activities which have been lumped together and described as *global mental health*. This movement is a relative newcomer to the global health movement.

The history and antecedents of any movement can shed light on the challenges and opportunities associated with it. Social movements are often triggered by some dissatisfaction or a crisis and by the vision of charismatic leaders. Examples are Martin Luther King Jr. and Mahatma Gandhi. Prior to a full discussion of the history of the global mental health movement, some background statements about globalization may be useful.

Globalization

There has been an abundance of definitions of globalization. Each definition highlights one or several themes, but all these definitions tend to emphasize the ascendancy of capitalism and interconnectivity in an ever-shrinking world space. This process has been driven by faster communication, enhanced by the internet and mass communication, faster and more efficient transportation of persons, and quicker and more efficient transfer of information, data, and currency. Perhaps one of the best definitions of globalization is afforded by Giddens (1990), who stated that:

> Globalization can thus be defined as the intensification of worldwide social relations which link distant localities in such a way that local happenings are shaped by events occurring many miles away and vice versa.
>
> (Giddens 1990, p. 64)

Four major dimensions can be distilled from the definitions and descriptions of globalization, which have relevance for global health and mental health. These dimensions are historical, economic, political, and sociocultural. A primary objective of global health and mental health is the eradication of disparities in terms of access to care, quality of life, and well-being worldwide.

- **Historical dimension** – This dimension is very relevant in discussions about global health. Many countries in the developing world have until recently experienced a colonial past. The consequences of this for developing countries are increased suspicion and sensitivity towards the actions of superpowers. "I fear donors when they bring gifts" (Trojan war). In fact, in some quarters, globalization has been described as "neo-colonization" (Akindele *et al.* 2002). In other words, globalization and its attendant processes can be seen as a back-door strategy to continue colonial domination.
- **Economic dimension** – This dimension is a powerful one in a world system where there are now very few dominant financial markets. The powerful nations exercise greater influence while the poorer ones are at risk of greater marginalization. Although the stated vision and goal of the International Monetary Fund and World Bank is the eradication of poverty

Essentials of Global Mental Health, ed. Samuel O. Okpaku. Published by Cambridge University Press. © Cambridge University Press 2014.

© in this web service Cambridge University Press www.cambridge.org

CAMBRIDGE

Cambridge University Press
978-1-107-02232-4 - Essentials of Global Mental Health
Edited by Samuel O. Okpaku
Excerpt
More information

worldwide and improved quality of life and well-being for all, there are examples of negative consequences of globalization in low- and middle-income countries (LMICs). There is an exacerbation of poverty in Africa where foreign direct investment (FDI) is falling (UNCTAD 2012).

- **Political dimension** – This domain deals mostly with health, development, and security. In this domain are issues related to the prevention of pandemics and access to affordable pharmaceuticals (e.g. the availability of cheap antiviral medications) (Safreed-Harmon 2008). In this regard, Brazil declared the right to health as a human right. Also, poor health is linked to loss of economic and political viability (United Nations General Assembly 2009).
- **Sociocultural dimension** – The fourth theme in globalization is "a process of cultural mixing and hybridization across locations and identities" (Appadurai 1996). The internet, social media, and mass communications enable individuals to negotiate through different cultures and be subject to different sociocultural forces in real time.

The above themes intersect and are a background to their influences. The resulting opposition to these influences can make understandable the protests against the World Trade Organization (WTO) meetings in Seattle in 1999, Japan in 2003, and Geneva in 2009.

Parenthetically, the same is true of the opposition to the Movement for Global Mental Health and the Grand Challenges of Mental Health. This opposition focused on the lack of attention to local institutions, traditions, and culture as well as that which is intrinsic in capitalism and cultural imperialism. This opposition is to be valued for its watchdog function and for providing the opportunity for reasonable debate. The Movement for Global Mental Health and Grand Challenges of Mental Health are activist programs. Similarly, the opposition to them, especially in the transcultural communities, is also activist. These polar positions are very useful in generating debate in order to protect the poor countries and institutions from further domination from developed countries and their institutions. So the contentious debates are therefore necessary, provided they are held in an honest and disciplined manner.

With that background in mind, what are global health and global mental health?

Global health and global mental health

A frequently used definition of *global health* is that of Koplan and colleagues (2009), who referred to global health as:

> an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide. Global health emphasizes transnational health issues, determinants, and solutions; involves many disciplines within and beyond the health sciences and promotes interdisciplinary collaboration; and is a synthesis of population-based prevention with individual-level clinical care.
>
> (Koplan *et al.* 2009)

Patel extended this approach to mental health, to come up with a definition of *global mental health* (Patel & Prince 2010).

In this chapter, I would like to suggest a different definition for global mental health, seeing it as a range of activities concerned with mental health that meet five principal criteria:

(1) **Universal and transnational criterion** – The problem/issue should have a universal or transnational aspect. Examples will be the role of poverty in mental illness worldwide and stigma reduction worldwide.
(2) **Public health criterion** – The problem should have a population basis, e.g., violence as a public issue.
(3) **Stakeholders criterion** – The composition of the stakeholders should be international in either bilateral or multilateral arrangements. They could be educational or scientific institutions, government bodies, non-governmental organizations (NGOs), or individuals.
(4) **Problem ownership criterion** – The problem should be owned by the recipient organization, institution, or country.
(5) **Team criterion** – The teams engaged in the project should be multidisciplinary and multi-party.

The above definition enables us to distinguish *global mental health* from *community mental health*, since the two movements have different philosophical backgrounds.

© in this web service Cambridge University Press www.cambridge.org

CAMBRIDGE

Cambridge University Press
978-1-107-02232-4 - Essentials of Global Mental Health
Edited by Samuel O. Okpaku
Excerpt
More information

The history of global mental health: three epochs

Global mental health can be traced to a confluence of several influences. One such influence has been the "vision," "imagination," and indefatigability of a set of luminaries – some of whom have suffered the pangs of emotional distress with its attendant humiliation, ostracism, and stigma and others for whom there is less evidence of direct mental illness. For the latter group, their primary motivation appears to be humanitarian. Another major influence was the experience of World War II, which led to extreme barbarism and unbelievable cruelty among men. The third influence has been a resurgence of humanitarianism, a sense of equity bolstered by the Millennium Fund, and a sense that we are all in this together.

The evolution of global mental health is a trajectory that can historically be divided into three epochs. For each epoch, it is possible to identify individuals or agencies that have played a significant role or are currently active in the process. The first epoch was dominated by two Americans, Dorothea Dix and Clifford Beers, who were non-psychiatrists. The second epoch was dominated by prominent social scientists and social psychiatrists, and by the activities of three major organizations, the World Federation for Mental Health (WFMH), the World Health Organization (WHO), and the World Psychiatric Association (WPA). The third epoch is the contemporary era, spearheaded by the Movement for Global Mental Health and the Grand Challenges in Global Mental Health.

The first epoch

As indicated above, Dorothea Dix and Clifford Beers contributed immensely to global mental health and had experiences of mental illness, making their contribution more instructive.

Dorothea Dix (1802–1887)

Dorothea Dix was an individual without any medical training who became very influential in the USA and abroad as an advocate for the humane treatment of mentally ill people. Her father is generally described as an abusive alcoholic. Her grandmother was reputed to be very wealthy, and she contributed to the discipline and training of the young woman. Under her influence Dorothea came into contact with powerful and influential individuals in the Massachusetts area (Tiffany 1890). Dorothea was a Unitarian, and it was reported that she had a call to promote the status of mentally ill individuals and improve their treatment and living conditions. She previously had taught neglected and poor children at home. Meanwhile, she began to visit centers for the custody and treatment of the mentally ill. She was appalled by the conditions she saw. She chronicled her observation of these treatment centers and gave her reports to state legislatures. This resulted in changes in the custody, accommodation, and treatment of mentally ill people. Her activities spread beyond Massachusetts to other states in the United States. This resulted in the creation of large state hospitals. At that time that trend was considered progressive, though that opinion has since changed, especially since de-institutionalization.

Dorothea Dix herself had frequent episodes of mental illness. In attempting to receive respite from one of these episodes, she visited England and met some like-minded individuals interested in reforming the treatment and improving the welfare of those with mental illness. Upon her return to the United States, she continued to investigate the conditions of the mentally ill in state asylums. She worked on a Bill for the benefit of the indigent and the insane. This Bill stipulated that 12 225 000 acres of federal land be set aside for the benefit of such individuals. The Bill passed both houses of Congress, but President Franklin Pierce vetoed it. Disappointed, she returned to the United Kingdom and, reuniting with her co-advocates, conducted surveys of asylums in Scotland and other European countries and chronicled her observations (Tiffany 1890).

With the outbreak of the American Civil War, Dorothea Dix was appointed as the Army's Superintendent of Nurses. Unfortunately, she did not succeed in this capacity and subsequently moved to Morris Plains, New Jersey, where a suite in a state hospital was designated for her private use. She subsequently died and is buried in Cambridge, Massachusetts (Tiffany 1890).

Clifford Beers (1876–1943)

This was the other notable figure to influence advocacy on behalf of mentally ill individuals before World War II. Clifford Beers was born to an upper middle class family. He had four brothers, all of whom suffered from mental illness (Beers 1908). He was able to observe the treatment being meted out to

© in this web service Cambridge University Press www.cambridge.org

CAMBRIDGE

Cambridge University Press
978-1-107-02232-4 - Essentials of Global Mental Health
Edited by Samuel O. Okpaku
Excerpt
More information

fellow mentally ill individuals. He himself suffered the same humiliations in private and public hospitals in Connecticut.

Beers was a Yale University student and had studied business. He subsequently wrote a book entitled *A Mind That Found Itself* (Beers 1908, Human Spirit Initiative 2009). He became very influential in the field of mental health, and with the support of prominent individuals such as Professor Adolf Meyer of Johns Hopkins Hospital he launched a movement to reform the treatment of mentally ill individuals in Connecticut and subsequently all over the United States.

In 1909 Clifford Beers founded the Connecticut Committee for Mental Hygiene. The following year its national counterpart, the American Mental Health Movement, was founded, and in 1919 followed the International Committee for Mental Hygiene. In 1930, this organization was reorganized as the First International Congress of Mental Hygiene. This was the origin of the World Federation for Mental Health (Brody 2004).

The second epoch

The second epoch is the period of World War II and the years immediately after. The war had caused great devastation and human suffering. This period was the heyday of cultural and social psychiatry. Margaret Mead and Bronislaw Malinowski, two anthropologists, emphasized the cultural influences in the development of personality and human organizations. Mead worked in Samoa and is well known for her book *Coming of Age in Samoa*, and Malinoswki did his research amongst the Trobriand Islanders. It disputed Freud's theory of the Oedipus Complex.

The second epoch was dominated by the activities of certain individuals as well as the activities of three major organizations. These individuals were Drs. George Brock Chisholm, John Rawlings Rees, and Harry Stack Sullivan, all of whom played a significant role in the founding of the WFMH (Brody 2004). The three organizations are the World Federation for Mental Health (WFMH), the World Psychiatric Association (WPA), and the World Health Organization (WHO).

Dr. George Brock Chisholm (1896–1971)

Chisholm, a Canadian and a veteran of World War I, was the first Director-General of the WHO. During World War II, he rose within the ranks of the Canadian military very quickly and was appointed Director-General of Medical Services, becoming the first psychiatrist to head the medical ranks of any army in the world. In 1944, Chisholm was appointed a Deputy Minister of Health in Canada, a post he almost lost because of some of his outspoken pronouncements. He frequently expressed the idea that man's worst enemy was man himself: "The world was sick and the ills from which it was suffering were mainly due to the perversions and his inability to live at peace with himself." He also believed that children should be raised in environments bereft of the moral, political, and religious biases of their parents (Lescouflair 2003).

In 1944, Brock Chisholm also became the Executive Secretary of the Interim Commission of the WHO, and he was one of 16 national experts consulted in drafting the agency's first constitution. It was Chisholm's view that health is a "state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." He contributed to the founding of the WFMH (Lescouflair 2003).

Dr. John Rawlings Rees (1890–1969)

John Rawlings Rees, like Brock Chisholm and Dorothea Dix, came from a religious background. Dix and Chisholm were Unitarians, and Rees was from a Wesleyan background (Trist & Murray 1989). He was a director of the Tavistock Clinic in London. In 1939, he was invited to take command of British Army psychiatry. He contributed to the British Army in many ways. He assembled a team of psychiatrists, and provided leadership in the screening and placement of inductees and in the education and training of recruits with limited intelligence. He later contributed to the First Mental Health Congress in London in 1948. With his close friend Brock Chisholm, he worked towards the formation of the WFMH, of which he was a director for many years. He also believed in the social roots of mental illness and its treatment (Rees 1966).

Dr. Harry Stack Sullivan (1892–1949)

Harry Stack Sullivan was born in Norwich, New York, to an Irish family. He graduated from Chicago College of Medicine and Surgery (Kimble *et al.* 1991). Early in his career, he was a first lieutenant in the Army Medical Corps and served as US Veterans Bureau Liaison Officer to St. Elizabeth's Hospital in Washington, DC. He believed in the importance of early life experiences and the contribution of

© in this web service Cambridge University Press www.cambridge.org

CAMBRIDGE

Cambridge University Press
978-1-107-02232-4 - Essentials of Global Mental Health
Edited by Samuel O. Okpaku
Excerpt
More information

interpersonal relationships to the social environment (Rioch 1985). His experience in his role as a consultant at St. Elizabeth's led to important insights in his work with hard-to-reach patients. He died in 1949 in Paris, where he had attended a meeting of the Executive Board of the WFMH (Kimble *et al.* 1991).

World Federation for Mental Health (WFMH)

It was George Chisholm who suggested the creation of the WFMH. Its predecessor was the International Committee for Mental Health. Chisholm's idea was that this would be a non-governmental body that would provide a link between "grassroots" mental health organizations and the United Nations (UN). Another notable contributor to the founding of the WFMH was the anthropologist Margaret Mead. The original Federation began with membership of societies and not of individuals or countries.

Currently, membership in the WFMH is open to individuals, users and survivors, and mental health and disability societies. WFMH remains active in celebrating World Mental Health Day, organizing the biennial World Congress and stimulating advocacy for mental health. The Federation was very active in trying to place mental disorders on the same footing as the non-communicable diseases at the 2011 UN high-level meeting. That goal was not entirely realized, but a mention was made of mental illness. WFMH continues to push and mobilize for prioritizing the needs of the mentally ill (World Federation for Mental Health 2011).

World Health Organization (WHO)

The WHO was founded in 1948 after World War II and the demise of the League of Nations. The WHO, through its division of mental health, has played a vital role in several aspects of mental health worldwide. Its mission is:

> to reduce the burden associated with mental, neurological and substance use diseases, and to promote health world wide
>
> (World Health Organization 1998)

The core functions include:

- Partnership with other organization such as the WPA, WFMH, and other allied professional groups, stakeholders, and NGOs.
- Managing information by providing reliable data, statistics, and information on risk factors, disease burdens, available services, and resources.
- Guidance to interested parties by providing consultation and technical guidelines, training modules, and tools on the development of mental health policies and legislation, and management and policy support (WHO 2004).

At its founding, the overall objective of the WHO was the prevention of infectious diseases. Since then, its activities have broadened. In the 65 years since its founding, the WHO has played a considerable role in promoting mental health all over the world. It has carried out, supported, or publicized major epidemiological studies and promoted international efforts in such areas as the need for each country to have a mental health policy. It also has advocated efforts to reduce stigma. Recently, it has published a Mental Health Gap Action Programme (mhGAP), which is a program to:

- *Tackle priority* conditions – depression, schizophrenia and other psychotic disorders, suicide, epilepsy, dementia, disorders due to use of alcohol and illicit drugs, and mental disorders in children.
- Develop and implement an *essential mental health package* to improve service delivery and reduce inequity.
- *Target countries for intensified support*, i.e., low- and middle-income countries with the maximum burden and a large resource gap.
- Identify and roll out a *strategy to scale up* care (WHO 2008a).

In addition, it also has introduced the Atlas series; each publication in this series presents the latest estimate of global mental health resources available to prevent and treat mental disorders and help protect the human rights of people living with these conditions (WHO 2011a).

The WHO has engaged in efforts to draw attention to mental health as a significant component of health. A primary objective of the Atlas project is to raise public and professional awareness of the inadequacies of existing resources and services and the large inequities in their distribution at national and global level. Hence, "no health without mental health" (Prince *et al.* 2007). This is done in conjunction with WHO regional and country offices. This arrangement helps to assess support and strengthen country systems.

© in this web service Cambridge University Press www.cambridge.org

CAMBRIDGE

Cambridge University Press
978-1-107-02232-4 - Essentials of Global Mental Health
Edited by Samuel O. Okpaku
Excerpt
More information

World Psychiatric Association (WPA)

The WPA was founded in 1950 against the background of the period immediately after World War II. There is little doubt that the first-hand experiences of military psychiatrists of the unspeakable devastation wrought by the events of the war led to a desire to understand the inscrutability of war, as well as a desire to help end human suffering. All of this in turn led to the founding of many psychiatric, social welfare, and relief organizations. It is also possible that the dispersion of prominent psychiatrists from the European Continent to other parts of Europe and to the United States fuelled the genesis of psychiatric movements. No matter the impetus, the WPA has grown from it modest origins in 1950 to its current influential role as the world's premier psychiatry organization, with membership societies from 141 countries.

In a way, this was a golden age for psychiatry. There was the rise of psychiatric epidemiology, anthropology, sociology, cultural psychiatry, psychotherapy, and analysis. The field was replete with competitive explanations for mental suffering and treatment.

The predecessor to the WPA was the Association for the Organization of the World Congress of Psychiatry. The first World Congress was held in Paris in 1950, and the second in Zurich in 1957. Its object was to provide educational opportunities for psychiatrists. However, by its formal founding in 1961, the vision had broadened and deepened. The WPA also has contributed to issues of human rights and the political abuse of psychiatry within Russia, Eastern Europe and China. Together with the WFMH and the WHO, the WPA also works to reduce stigma (Patel *et al.* 2010)

In the last two decades, the WPA has increased its efforts in providing educational opportunities, particularly in low- and middle-income countries. Examples include its program on Teaching and Learning about Schizophrenia, the Educational Programme on Depressive Disorders, Social Phobia, the Core Curriculum in Psychiatry for Medical Students, and the Institutional Program on the Core Training Curriculum for Psychiatry (WPA undated)

The third epoch

The third epoch is contemporary, and it has evolved as a result of multiple influences.

The influence of the World Bank and World Health Organization

In 1988, the World Bank supported work that was published as a *Health Sector Priorities Review*. The goal was to have a sense as to "the significance to public health of individual diseases [or related clusters of diseases] and what is now known as the cost and effectiveness of relevant interventions for their control" (Jamison *et al.* 1993). (It is interesting that this work is regarded as being intellectually antedated by work carried out in Ghana, a developing country, by the Ghana Health Assessment Project Team in 1981.) For the *Health Sector Priorities Review* Dr. Christopher Murray introduced the term disability-adjusted life year (DALY). Subsequently Christopher Murray and Alan Lopez edited the *Global Burden of Disease* report. Their work enabled comparisons between different diseases in terms of their contributions to mortality and disability. The measure now incorporates risk factors for different disease groups including mental health and neurological disorders. Mental ill health and neurological conditions contribute about 14% of the burden of disease. Depression contributes about 6% to this burden. It is a matter of concern that suicide has become the highest killer in adolescence in several countries (Murray & Lopez 1996).

In 2003 the WHO commissioned a report on the *Social Determinants of Health*. The report outlined the relative impact of policies, health systems, environmental factors, lifestyle factors, and biology that contribute to well-being and quality of life. These factors are multisectoral and multilevel, hence the need to provide comprehensive approaches to enhance an individual's quality of life and improve the community's health productivity and robustness. The commissioners called for social justice and equality as well as the need to close the health gap in a generation (WHO 2003).

In 2008 WHO published the *Mental Health Gap Action Program* (mhGAP). This volume documents the gap between the service needs and what is available for the treatment of mentally ill people worldwide, especially in low- and middle-income countries. The mhGAP has been followed up by the *mhGAP Intervention Guide* (mhGAP-IG) that provides a grid for the treatment of mentally ill individuals. These interventions are not cast in stone but rather they provide a framework for dealing with disease entities (WHO 2008a, 2010).

© in this web service Cambridge University Press www.cambridge.org

CAMBRIDGE

Cambridge University Press
978-1-107-02232-4 - Essentials of Global Mental Health
Edited by Samuel O. Okpaku
Excerpt
More information

The above sequence of events and significant publications illustrates how WHO has systematically shown the need for care and offered suggestions for possible interventions for alleviating suffering and pain worldwide.

Advocacy, humanitarianism, ethics, and mass media

Another major influence in the development of contemporary global mental health is the synergistic relationship of factors such as advocacy, humanitarianism, ethics, and mass media. The mass media has contributed immensely by bringing to individual private rooms, in real time, natural and manmade disasters. Examples of such events are the Asian tsunami of 2004, Hurricane Katrina in 2005, and the rescue of the Chilean miners in 2010. In the last instance the international collaboration was broadcast all over the word. There was collaboration even in the equipment used in the rescue operation. The advocacy factor has been enhanced by the reports of the Commission on the Social Determinants of Health. The report was approved by member states at the 2011 Rio de Janiero Conference (WHO 2011b). Another influential contribution is the role of faith-based organizations. It is likely that this role will expand as the definition of health expands to include matters concerning food and water security and climate change.

Human resources and brain drain, task shifting and sharing

Although no nation can boast of having enough health workers to meet the needs of its citizenry, the problem for developing countries is acute. This problem is made worse by the "brain drain" of health professionals from developing countries to developed countries. It is estimated that 57 countries have a severe shortage of healthcare workers, and 36 of these countries are African (WHO 2008b). This has led to strategies to improve efficiencies in the health systems. Task shifting, which means the delegation of some services to less specialized individuals to free up the highly trained individuals to focus on the more difficult or technical issues, has been derived from experiences in the treatment of HIV/AIDS. More recently some critics are suggesting that a team approach – task sharing, not task shifting – is the way to go. Such critics emphasize that nurses provide a substantial part of the care of HIV/AIDS patients, and that HIV cannot be controlled without the services being provided by nurses (Olson 2012).

The latest epoch of global mental health also was advanced by the publication in 2007 of a series of articles in *The Lancet*. That edition contained a call for action (Lancet Global Mental Health Group 2007). Subsequently, a group of mental health professionals and allied professionals joined to form the Movement for Global Mental Health (MGMH). Since its inauguration, the group has held two biennial conferences, the first in Athens in 2009 and the second in Cape Town in 2011. These meetings were held under the auspices of the WFMH, and at Cape Town a second set of *Lancet* papers was released. The group consists of individuals and institutions with a commitment to improve the plight of mentally ill individuals worldwide, with particular emphasis on low- and middle-income countries. The group emphasizes two major principles, namely, evidence-based approaches and protection of human rights (Lancet Global Mental Health Group 2007). Meanwhile, a project funded by the US National Institute of Mental Health (NIMH) produced a document titled *Grand Challenges in Global Mental Health*. Participants in the project consisted of mental health experts with representation from low- and middle-income countries. Their opinions were sought as to the priorities in scaling up mental health services and research in those countries (Collins *et al.* 2011).

There is no doubt that global health has been greatly influenced by the availability of funds prompted by the availability of the Millennium Development Goals. At the historic summit meeting at the UN headquarters in New York in September 2000, 189 heads of states passed a sweeping resolution designed to eradicate poverty and improve the quality of life worldwide, but especially in the poor low-resource countries (United Nations Development Group 2000). The declaration has eight goals, three of which are specific to health, while the other five have health implications, although not so directly. The goals are financial strategies to be achieved by 2015. The International Monetary Fund (IMF) plays a significant role through various economic and financial strategies which are regarded as more favorable than before by low-income countries. The declaration serves to mobilize public policy agendas for member states (United Nations Development Group 2000).

© in this web service Cambridge University Press www.cambridge.org

CAMBRIDGE

Cambridge University Press
978-1-107-02232-4 - Essentials of Global Mental Health
Edited by Samuel O. Okpaku
Excerpt
More information

Commentary and criticism

Quite naturally we do not expect the ideology and the concepts of the MGMH to be accepted universally. There have been strong criticisms of the movement, especially in the transcultural community. Perhaps some of the most vocal criticisms have come from Derek Summerfield, who states "Psychiatry has no answer to the question 'what is a mental disorder?', and instead exalts a way of working it has devised . . . What exactly is 'global mental health'? Can any definition or standard of mental health be definitive universally?" (Summerfield 2012). He has reservations about the term *global mental health*, emphasizing the need for cultural relevance of programs and pointing out that it is unacceptable to apply Western definitions and treatment approaches to non-Western societies.

Suman Fernando stated that "The 'global mental health' movement being pursued by the US NIMH requires considerable modifications if it is to be ethically acceptable in a post-colonial world. Otherwise, the result will be the imposition of Euro-American psychiatry en masse, amounting to cultural imperialism" (Advanced Senior Institute of Transcultural Psychiatry 2012). It is intriguing that considerable energy is being expended in this discussion. We have previously indicated that all psychiatric endeavors are transcultural. So culture is intrinsic in all discussions of mental illness. As an African, but one who has never had the privilege to work in Africa, in my discussions with my colleagues who work in Africa, we seem to come from two worlds. The following is an illustration. In the Western world, there is a standardized protocol for the treatment of alcohol withdrawal, and this is to use benzodiazepines. According to my associates in Africa, the corresponding treatment in Africa is sometimes to encourage the family to purchase more alcohol for the patient to prevent delirium tremens.

An important aspect of global mental health will be the imperative to explore how new and indigenous ways deal with local mental health problems and definitely not attempt to impose Western approaches. Considering examples, especially of places such as the United States, where homelessness is a scourge, or the United Kingdom, where the National Health Service is on the brink of disarray, low- and middle-income countries have to devise their own strategies that take into consideration their local conditions in developing mental health systems. At a recent conference, I was informed by a Ugandan colleague that the success rate for the treatment of depression is higher in Uganda than in the United States. This raises several issues. My opinion is that possibly the profiles of the patients are different in the two countries. Perhaps in Uganda individuals seeking treatments have more serious illness with biological substrates, while in the United States one is dealing with a social problem relative to the social security system. It is not unusual for the American indigent patient to seek continued hospitalization and then to become well at the prospect of his next check, or for individuals to abuse their allotment of annual Medicaid days. Although opposed to the practice of polypharmacy, considering the comorbidities of physical illness and mental illness, in my clinical practice and those of my colleagues, it is not unusual to prescribe for a patient on 10 medications simultaneously. For example, take a male patient who is 65 years old. He has a diagnosis of hypertension, type 2 diabetes, hypercholesterolemia, and major depressive disorder. For his hypertension and diabetes, he is prescribed three medications each, and for his depression two medications (one antidepressant, one antianxiety hypnotic), and for his hypercholesterolemia he is prescribed one medication. His prescription can easily cost between US$1000 and US$1500 per month. This sum would be an enviable income for a family of four in many low- and middle-income countries. Hence new and alternative pathways have to be developed not only for developing countries but also for developed countries where the cost of pharmaceuticals has become exorbitant. So it is incumbent on all stakeholders to explore locally relevant approaches in dealing with problems while being open to outside influences.

The future of global mental health

The future of global health and mental health is likely to be influenced by a variety of driving factors. One of these is activism. This implies a greater role for civil society, patient advocates, and users/survivors as well as their families and communities. WHO agreements, various national policies, and international mental health agencies support this position.

A related driving force is the reduction of stigma and exclusion. Education about mental illness, alongside the rehabilitation and work placement of users/survivors, will continue to be welcome. Related to the

© in this web service Cambridge University Press www.cambridge.org

CAMBRIDGE

Cambridge University Press
978-1-107-02232-4 - Essentials of Global Mental Health
Edited by Samuel O. Okpaku
Excerpt
More information

above driving factors is the need for self-help and country ownership. Although these concepts have been more prominent in HIV/AIDS treatment and research, it should be anticipated that this trend will spread to other areas.

Another major driving force is the changing perception in the definitions of health and mental health. We have come a long way since the founding of WHO 65 years ago, when the emphasis was on the prevention and management of infectious diseases. Now health and foreign policy of progressive nations make references to quality of life and human dignity. Recently, at least two countries have appointed global health ambassadors. Greater importance is given to the social determinants of health. Poverty, immigration, person trafficking, and modern slavery are highlighted. Mass killings, national and international conflicts and wars draw attention to the role of violence as a risk for mental illness. The current situation is underscored by the spate of mass killings in the USA and the debate over gun ownership. In addition, the mental health consequences of the wars in Iraq and Afghanistan are widespread.

Climate change issues, immigration issues, water shortage, and poverty have their related global mental health consequences. It is anticipated that these issues will continue to hold some presence in foreign policies and international discourse.

An area of promise is the greater implementation and integration of research, policy, and practice. Another level of prominence will come with the increasing integration of mental health services into primary care practices and centers.

Telemedicine and ehealth and other technological advances are likely to shape the future of mental health services in enhancing capacity for service delivery and research, especially in low-resource areas. Related to telemedicine and ehealth is the expansion of task shifting. With the current predictions of increased depression and suicide in the next few decades, the human resources to deal with this demand will have to depend on the availability of community supports.

Lastly, funding remains a major driver in the provision of service delivery and support for research. This is likely to be affected by the contractions and expansions of the economies of the developing countries. It is anticipated that the emerging economies such as the Brazil, Russia, India, China, and South Africa (BRICS) will assume a greater role as donor countries.

Summary

In summary, we have attempted to trace the history of global mental health. We have also described some of the most influential driving factors. There is a clear need to define and operationalize global mental health to improve communication and scholarship. The concerns of global mental health focus largely on the most needy communities, in the low- and middle-income countries, but the vision is worldwide. We must not assume that poverty is restricted to developing countries. Homelessness is worldwide; stigma in people suffering from mental health problems is also worldwide. Human rights abuse of the mentally ill is universal. While we cannot seek a utopia it is nevertheless heartening that the UN and its major health agency the WHO, as well as the related international agencies, the World Bank and IMF play significant roles in contributing to the success of the landmark commitments enshrined in the Millennium Development and Rio de Janeiro treaties. These two treaties affirm a commitment from the UN member states to the eradication of health inequalities and a chance for equitable, dignified, and productive life for all people worldwide irrespective of race, gender, age, or socio-economic class. We are all in this together.

References

Advanced Senior Institute of Transcultural Psychiatry (2012) *Why Mental Health Matters to Global Health*. Montreal: Advanced Senior Institute of Transcultural Psychiatry.

Akindele ST, Gidado TO, Olaopo OR (2002) Globalisation, its Implications and Consequences for Africa. http://globalization.icaap.org/content/v2.1/01_akindele_etal.html (accessed Juy 2013).

Appadurai A (1996) *Modernity at Large: Cultural Dimensions of Globalization*. Minneapolis, MN: University of Minnesota Press.

Beers C (1908) *A Mind That Found Itself*. Pittsburgh, PA: University of Pittsburgh Press.

Brody, E (2004) The World Federation for Mental Health: its origins and contemporary relevance to WHO and WPA policies. *World Psychiatry*. **3** (1): 54–55.

Collins PY, Patel V, Joestl SS, *et al.* (2011) Grand challenges in global mental health. *Nature* **475**: 27–30.

© in this web service Cambridge University Press www.cambridge.org

CAMBRIDGE

Cambridge University Press
978-1-107-02232-4 - Essentials of Global Mental Health
Edited by Samuel O. Okpaku
Excerpt
More information

Giddens A (1990) *The Consequences of Modernity*. Cambridge: Polity Press.

Human Spirit Initiative (2009) *Clifford W. Beers: the Founding of Mental Health America 1908–1935: Telling the Story and Showing the Way*. Minneapolis, MN: Human Spirit Initiative.

Jamison DT, Mosley WH, Measham AR, Bobadilla JL, eds. (1993) *Disease Control Priorities in Developing Countries*. New York, NY: Oxford University Press for the World Bank.

Kimble GA, Wertheimer M, White C (1991) *Portraits of Pioneers in Psychology*, Vol. 1. London: Routledge.

Koplan JP, Bond TC, Merson MH, *et al.* (2009). Towards a common definition of global health. *Lancet* **373**: 1993–5.

Lancet Global Mental Health Group (2007) Scale up services for mental disorders: a call for action. *Lancet* **370**: 1241–52.

Lescouflair E (2003) *Brock Chisholm: Director-General, World Health Organization 1896–1971*. Cambridge, MA: Harvard Square Library.

Murray CJL, Lopez AD (1996) *The Global Burden of Disease: a Comprehensive Assessment of Mortality and Disability from Diseases, Injuries, and Risk Factors in 1990 and Projected to 2020*. Cambridge, MA: Harvard University Press.

Olson D (2012) Task sharing not task shifting: team approach is best bet for HIV care. *Global Health Blog*. http://www.intrahealth.org/page/task-sharing-not-task-shifting-team-approach-is-best-bet-for-hiv-care (accessed July 2013).

Patel V, Prince M (2010) Global mental health: a new global health field comes of age. *JAMA* **303**: 1976–7. doi: 10.1001/jama.2010.616.

Patel V, Maj M, Flisher AJ, *et al.* (2010) Reducing the treatment gap for mental disorders: a WPA survey. *World Psychiatry* **9** (3): 169–76.

Prince M, Patel V, Saxena S, *et al.* (2007) No health without mental health. *Lancet* **370**: 859–77.

Rees JR (1966) *Reflections: a Personal History and An Account of the Growth of the World Federation for Mental Health*. New York, NY: WFMH.

Rioch DM (1985) Recollections of Harry Stack Sullivan and of the development of his interpersonal psychiatry. *Psychiatry* **48** (2): 141–58.

Safreed-Harmon K (2008) Human rights and HIV/AIDS in Brazil. *GMHC Treatment Issues*. http://www.gmhc.org/files/editor/file/ti_poz_0408.pdf (accessed July 2013).

Summerfield D (2012). Afterword: against "global mental health". *Transcultural Psychiatry* **49** (3) 1–12.

Tiffany F (1890) *The Life of Dorothea Lynde Dix*. Boston, MA: Houghton, Mifflin.

Trist E, Murray H (1989) The foundation and development of the Tavistock Institute to 1989. http://www.moderntimesworkplace.com/archives/ericsess/tavis1/tavis1.html (accessed July 2013).

United Nations Conference on Trade and Development (UNCTAD) (2012) Global flows of foreign direct investment exceeding pre-crisis level in 2011, despite turmoil in the global economy. *Global Investment Trends Monitor* (8).

United Nations Development Group (2000) *Millennium Declaration*. New York, NY: Millennium Development Goals Summit.

United Nations General Assembly (2009) Global health and foreign policy: strategic opportunities and challenges. Note by the Secretary-General. (A/64/365). New York, NY: UN.

World Federation for Mental Health (2011) World Federation for Mental Health Activities at the United Nations for 2010–2011. Conference on advocacy for the inclusion of mental health among Non-Communicable Diseases.

World Health Organization (1998) *Primary Prevention of Mental, Neurological and Psychosocial Disorders*. Geneva: WHO.

World Health Organization (2003) *Social Determinants of Health: the Solid Facts*. Based on the World Conference on Social Determinants of Health. Geneva: WHO.

World Health Organization (2004) *Prevention of Mental Disorders: Effective Interventions and Policy Options*. Geneva: WHO.

World Health Organization (2008a) *mhGAP: Mental Health Gap Action Programme. Scaling up Care for Mental, Neurological, and Substance Use Disorders*. Geneva: WHO.

World Health Organization (2008b) *Task Shifting: Rational Redistribution of Tasks Among Health Workforce Teams: Global Recommendations and Guidelines*. First Global Conference on Task Shifting Addis Ababa, Ethiopia. Geneva: WHO.

World Health Organization (2010) *mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings*. Geneva: WHO.

World Health Organization (2011a) *Mental Health Atlas 2011*. Geneva: WHO.

World Health Organization (2011b) Rio Political Declaration on Social Determinants of Health, Rio de Janeiro, Brazil, 21 October 2011. World Conference on Social Determinants of Health.

World Psychiatric Association (undated) WPA Educational Programs *Core Training Curriculum for Psychiatry* Retrieved from http://www.wpanet.org.

© in this web service Cambridge University Press www.cambridge.org