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Critical perspectives on the NIMH initiative "Grand Challenges to Global Mental Health"

In July 2011 Nature carried a Comment titled "Grand Challenges to Global Mental Health" (1) announcing research priorities to benefit people with mental illness around the world. The essay called for urgent action and investment. However, many professionals, academics, and service user advocate organisations were concerned about the assumptions embedded in the approaches advocated and the potential for the project to do more harm than good as a result. Nature refused to print a letter (sent on 20th August 2011) protesting against the issue, citing 'lack of space' as the reason.

This letter is an effort to critique the initiative through wide participation and consensus.

Background

The largest international Delphi panel ever was assembled in a project starting March 2010 to formulate the 'Grand' Challenges to Global Mental Health project. The panel consisted of a scientific advisory board from the US National Institute of Mental Health who "nominated 594 researchers, advocates, programme implementers, and clinicians...researchers in genetics and genomics, neuroscience, basic behavioural science and neurodevelopment made up just over one-third of the panel. Mental health services researchers constituted another quarter, and a further third were clinical researchers and epidemiologists" (p 28).

The panel listed 25 grand challenges including biological, social and genetic factors that needed to be identified and tackled.

While environmental influences and community care were mentioned, the main framework for the project utilised a narrow 'medical' model for understanding mental distress that emphasised treating mental, neurological and substance-use (MNS) disorders through improved understanding of the brain, its cellular and molecular mechanisms. Fourteen MNS disorders were listed including unipolar depressive disorders, alcohol-use, schizophrenia, bipolar affective-disorders, epilepsy, panic disorder, migraine, insomnia, PTSD, and Parkinson's disease. The fact that disorders likely to be linked to adverse experiences

(such as depression) were put alongside known organic pathologies (such as epilepsy) illustrated the lack of inclusion of lived social and political realities in the models for causation and manifestation of mental distress. In addition, while the authors proposed 'understanding root causes, risk and protective factors' including poverty, violence, war, migration and disaster, the essay largely advocated biomedical, clinical or 'social services' oriented measures to alleviate the distress, with no protest, voice or opinion against the root causes listed. They argued that MNS disorders constituted 14% of the global burden of disease surpassing cancer and cardiovascular diseases with a global loss of disability adjusted life years at 148.8 million. This programme is now growing in strength as it is being rolled out internationally (2).

Problems with the Grand Challenges project

The following are some of the main problems with adhering to the 'Grand Challenges' proposal:

- a) We agree about the need to improve mental health in non-western countries, but are concerned about the approach of the 'Delphi panel' as developing appropriate frameworks for mental health requires active collaboration with local communities and with those with personal experience of mental health problems. The Delphi panel was not representative of these stakeholders. The data on which the Delphi panel bases its recommendations is also questionable and could grossly exaggerate the global burden of mental disorders.
- b) The focus on 'molecular and cellular mechanisms' in the brain for the complex problems of living ignores the experiences of ordinary people and the different settings in which mental health problems manifest.
- c) The recommendations overlook indigenous healing, social support networks, rights-based organizations and family support.
- d) The assumption of a global norm for mental health and the idea that deviations can be subsumed within a simplistic biomedical framework is restrictive and disconnected from the real lived experiences of potential service users.
- e) Mental health services should not be dependent on funds driven by pharmaceutical, insurance and other industries with potential conflicts of interest.
- f) The picture of a black girl chained to a tree on the front page of their paper in Nature suggests that rights violations are a more prevalent issue in non-western countries. Mental health service delivery has involved rights violations across the globe (e.g. use of seclusion, restraint, high dose medication).

Instead we propose that protections, in line with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), should be at the centre of developing mental health programmes. These programmes should also be developed in a way that reflects the experience of local communities.

A framework that emphasizes respect for persons requiring services would result in approaches that are interactive and not imposed (as is the case in most Western countries).

If the US-NIMH is concerned about the lives of people in LMI countries it should be in dialogue with representative stakeholders, and not impose solutions identified by non-representative experts.

We the undersigned are concerned activists and practitioners who come from different representative organizations like MFC, Anveshi and CAMH in India, and Survivor Research, ICPN, the UK.

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Psychiatric advance directives: cultural reflections

The article by Sarin et al (1) on the subject of psychiatric advance directives (PADs) raises new problems which are particularly challenging in the Indian context. The debate so far has focused on issues of competence, access, resources and legal dilemmas. What is missing is a discussion on the cultural aspects of mental healthcare for the Indian population.

Advanced directives are anchored in the bioethical principle of autonomy. The concept of autonomy as applied in western biomedicine implies self-determination and individual independence. This may not be the case in a different cultural context (2,3). Sarin et al have rightly pointed out, but not elaborated on, the role of family/key caregivers' preferences and views, and their impact on PADs and decision-making. This is also suggested in research findings on advanced directives in end-of-life care in cultures outside Europe and North America. Thus autonomy may imply "self-sovereignty" and "individual independence" in one culture, but "family-sovereignty" and "harmonious dependence" in another (3).

There is a more contentious issue related to the dominant form of mental healthcare legitimised by the state, in policy, programmes, and state-sponsored services. Research in mental

healthcare (4-9) has made evident the cultural construction of dominant biomedical paradigms of psychiatric care, and reveals the existence of other types of care that do not rely on biomedical treatment.

However, given the domination of biomedical treatment, requests for other types of care may be interpreted as non-viable. Under the circumstances the clinician may overrule PADs apparently in support of beneficence at the cost of autonomy.

In other words, legal instruments such as PADs may justify cultural bias and further marginalise those who seek mental healthcare outside mainstream medicine. As a result, they defeat the purpose of non discrimination and enhanced mutual acceptability of treatment decisions (1) for which PADs have been designed.

Sarin et al recommend research in PADs around feasibility, acceptability and effectiveness, in the Indian context. This can be advanced by culturally informed research. And, because personal integrity is threatened in severe mental disorders, primarily due to loss of insight, it is important to research these disorders and people's preferred methods for restoration, of integrity. This is because people's preferences relate to PADs in a definite manner.

The paper by Sarin et al is commendable, considering the variety of issues it brings to the fore that may add substantial value to the discourse on PADs. To be a fruitful legal mechanism, PADs should facilitate the aligning of culturally appropriate services with treatment needs.

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