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THE PALGRAVE HANDBOOK OF SOCIOCULTURAL PERSPECTIVES ON GLOBAL MENTAL HEALTH

Edited by
Ross G. White, Sumeet Jain, David M.R. Orr, Ursula M. Read

The Palgrave Handbook of Sociocultural Perspectives on Global Mental Health

Ross G. White • Sumeet Jain • David M.R. Orr • Ursula M. Read
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To the memory of Kanyi Gikonyo and Duncan Pedersen

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Situating Global Mental Health: Sociocultural Perspectives

Ross G. White, David M.R. Orr, Ursula M. Read, and Sumeet Jain

Understanding the Emergence of Global Mental Health

Dating back through the millennia, much evidence bears witness to the fascination that humankind has had with endeavouring to understand the reasons for unusual or aberrant behaviour. For example, in the fifth century BCE in Greece, Hippocrates refuted claims that 'madness' resulted from supernatural causes and suggested, instead, that natural causes were responsible. In the intervening years, there has been a waxing and waning of various explanations of madness, including humours (i.e., blood, yellow bile, black bile and phlegm), the divine, the diabolical, the biomedical, the psychological and the social. Across time, geography and cultures, different labels and systems of classification have been employed to categorize manifestations of madness.

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Equally a diverse range of reactions have been bestowed upon those experiencing madness, including the trepanning of skulls, burning at the stake, veneration, provision of asylum, moral instruction, exclusion, incarceration, restraint, compassion, exorcism, spiritual healing, persecution, psychosurgeries, medication and psychotherapy. The diversity of these reactions has been influenced by the multitude of ideologies, doctrines and ethics that have shaped peoples' lives across different contexts.

Contemporary discourses about 'mental disorders' owe much to the emergence of 'Psychiatry' as a field of medicine. In the early nineteenth century CE, a German physician named Johann Christian Reil first coined the term 'psychiatry' ('psychiatrie' in German), which was an amalgamation of Greek words meaning 'medical treatment of the soul'. The early development of psychiatry centred on the contribution of key protagonists based in Europe (e.g., Freud, Bleuler, Jung). As such, psychiatric theory and practice were strongly influenced by European societal attitudes and sensibilities. However, as psychiatrists began to travel to other parts of the world, interest grew in the potential applications that psychiatry might have in diverse cultural settings. A key example of this came in 1904 when the German psychiatrist Emile Kraepelin visited Java to determine whether the diagnosis of 'dementia praecox' (a forerunner of what was to become a diagnosis of schizophrenia) existed there. This witnessed the birth of a new field of study that Kraepelin referred to as 'comparative psychiatry' (vergleichende psychiatrie). In 1925, Kraepelin conducted comparative psychiatric presentations in Native American, African American and Latin American people in psychiatric institutions in the USA, Mexico and Cuba (Jilek 1995).

Questions regarding the incidence of mental disorders in diverse societies and the universality of psychiatric diagnoses have continued since Kraepelin's work in the early twentieth century CE. However, international comparative epidemiological studies of any size only began during the 1960s with the World Health Organization (WHO)-sponsored epidemiological studies of schizophrenia (Lovell 2014). To this day, many countries lack nationally representative epidemiological data for both low-prevalence mental disorders (such as schizophrenia) and common mental disorders (such as depression and anxiety disorders) (Baxter et al. 2013). The provision of psychiatric treatment as a part of state-sponsored health care systems has also emerged unevenly, with the bulk of investment and innovations in forms of intervention and organization taking place in high-income countries (as classified by the World Bank). When health care systems were introduced by colonial governments in the nineteenth and twentieth centuries CE, mental health was a very low priority compared to public health and the control of infectious diseases. The few asylums constructed were concerned more with public order than treatment, and there was very limited investment in forms of community-based care (Keller 2001). Since independence, the health systems of many postcolonial governments have suffered from weak economies, fiscal deficit and the effects of structural adjustment. In such conditions, mental health care tended to be neglected (Njenga 2002).

Nonetheless, despite the limited global reach of epidemiological studies and of psychiatric interventions, a growing field of enquiry and practice emerged during this period, which came to be termed 'transcultural psychiatry'. Though this was and remains a diverse field, two notable aspects were the interests certain anthropologists had in cultural influences on mental disorders and societal responses, and the emergence of psychiatrists originating from the Global South who were trained in Europe and were attempting to apply universal diagnoses to local populations. This confluence of anthropologists and psychiatrists, some of whom had been trained in both disciplines, was strengthened after the 1950s by the beginning of large-scale migration from the former colonies to countries of Europe and North America and the growing numbers of patients from diverse cultures in psychiatric services. Academic departments and courses in transcultural psychiatry began to be established, notably at McGill in Canada and Harvard in the USA, and academic journals such as *Transcultural Psychiatry* began publication. In 1995, some of the most influential anthropologists in transcultural psychiatry based at Harvard University, including Arthur Kleinman, published a book entitled *World Mental Health: Problems and Priorities in Low-Income Countries* (Desjarlais et al. 1995). This volume set out the concerns regarding human rights, lack of treatment and rising incidence of mental disorders in terms that in many ways set the agenda for what was later to be termed 'Global Mental Health' (GMH). Six years later, the WHO brought renewed attention to mental health by making it the topic of their annual 'World Health Report' for the first time in its history (WHO 2001).

The term Global Mental Health was first coined in 2001 by the then US Surgeon General, David Satcher. Reflecting on the publication of the 2001 World Health Report (WHO 2001) and a year-long campaign by the WHO on mental health, Satcher (2001) proposed that the USA should bring mental health onto the global health (GH) agenda by 'taking a leadership role that emphasizes partnership, mutual respect, and a shared vision of improving the lives of people who have mental illness and improving the mental health system for everyone' (p. 1697). GMH was given additional visibility through the launch of *The Movement for Global Mental Health* (MGMH). The MGMH traces its origins back to the consortium of experts that constituted The Lancet Group for GMH (2007, 2011), and who published a range of papers to highlight the need for action to build capacity for mental health services in low- and middle-income countries. The MGMH now has a membership of around 200 institutions and 10,000 individuals (http://www.globalmentalhealth.org/about). Over the last 15 years, GMH has evolved from its embryonic roots to establish itself as a field of study, debate and action, which is now latticed by diverse disciplinary, cultural and personal perspectives. This has resulted in the term 'Global Mental Health' being employed strategically in different ways, for example, as a rallying call for assembling a movement of diverse stakeholders advocating for equity in mental health provision across the globe (i.e., MGMH); a target for critical debates around the universal relevance of mental health concepts and the globalization of psychiatry; a focus of academic study (such as postgraduate programmes in GMH), and a topic of research that has precipitated dedicated funding streams (e.g., by organizations such as *Grand Challenges Canada*).

Terminology and Epistemic Frames

Patel (2014) argues that GMH initiatives are characterized by a multidisciplinary approach that harnesses together the contributions made by diverse fields of expertise. At its best, this allows for an integrated, holistic approach to mental health challenges. However, concerns have been raised that psychiatric and biomedical perspectives have exerted a disproportionately high influence in shaping the GMH agenda (Mills 2014; White and Sashidharan 2014). *The Palgrave Handbook of Sociocultural Perspectives on Global Mental Health* seeks to extend understanding about GMH by drawing on diverse disciplinary perspectives, some of which have been under-represented to date. Specifically, the handbook includes contributions from people with a lived experience of mental health difficulties and academics, researchers and practitioners with backgrounds in anthropology, geography, law, history, philosophy, intercultural studies, social work, psychiatric nursing, occupational therapy, social psychology, clinical psychology and psychiatry. This brings together a broader range of epistemic frames and allows for recognition of mental health as an intrinsically complex and contested field. Such divergent epistemologies inevitably lead to different priorities in approaching the treatment of mental disorders described in this volume.

Within academic research and clinical practice, diagnostic manuals exist that provide criteria for diagnosing 'mental disorders' that are proposed to occur universally across cultures. However, there is contention about the appropriateness of applying the language of 'mental health/illness/disorders' across diverse cultural settings where aberrant psychological, emotional and/or behavioural states may not be conceptualized as being associated with either health or illness. The development of manuals for diagnosing mental disorders was predicated on the assumption that the criteria for these disorders could be universally applied across all individuals—an assumption that has been contested by those who advocate a relativist approach to understanding aberrant states that is sensitive to the beliefs and practices that particular groupings of people espouse (Summerfield 2008; Mills 2014). In recent decades, there has been a growing recognition in diagnostic manuals that certain aberrant states may be unique to particular cultural contexts. For example, the 4th edition of the American Psychiatric Association's *Diagnostic and Statistical Manual* (DSM-IV; APA 1994) listed 27 distinct 'culture bound syndromes' in an appendix, which were defined as 'locality-specific patterns of aberrant [deviant] behaviour and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category' (APA 1994, p. 844). There were, however, criticisms about the restrictive and skewed way in which the terminology 'culture-bound' was deployed. Some parties criticized the inadequacy of this approach by describing the appendix as 'little more than a sop thrown to cultural psychiatrists and psychiatric anthropologists' (Kleinman and Cohen 1997, p.76). These critiques were influential in shaping the changes that were subsequently made in the 5th edition of DSM (APA 2013). Indeed, DSM-5 acknowledges that '[A]ll forms of distress are locally shaped, including the DSM disorders' (APA 2013, p.758). Section III of DSM-5 includes a *Cultural Formulation Interview* (CFI) consisting of 16 questions and 12 supplementary modules intended to elicit information about the sociocultural context in which difficulties are experienced. In addition, the notion of 'culture-bound syndromes' has been replaced in DSM-5 by three concepts: (1) cultural syndromes: 'clusters of symptoms and attributions that tend to co-occur among individuals in specific cultural groups, communities, or contexts … that are recognized locally as coherent patterns of experience' (p. 758); (2) cultural idioms of distress: 'ways of expressing distress that may not involve specific symptoms or syndromes, but that provide collective, shared ways of experiencing and talking about personal or social concerns' (p. 758); and (3) cultural explanations of distress or perceived causes: 'labels, attributions, or features of an explanatory model that indicate culturally recognized meaning or etiology for symptoms, illness, or distress' (p. 758).

The role that psychiatric diagnosis should play in GMH initiatives continues to be a matter of debate. Some parties have criticized the use of psychiatric diagnoses on the grounds that these nosological classification systems lack adequate validity and that this may be further confounded by cultural variations in the manifestation, subjective experience and prognosis of mental health issues (Summerfield 2008; Mills 2014). It has been argued that standardized approaches to classifying phenotypes of *illness* can potentially play an important role in identifying biomedical causes of *disease* (Patel 2014). However, the approach used by existing diagnostic manuals may not be fit for this purpose. Responding to concerns that existing systems for making psychiatric diagnoses do not fully accord with neuro-scientific findings, the *National Institute for Mental Health* in the USA chose to abandon these systems and adopt a new approach referred to as *Research Domain Criteria* (Insel et al. 2010, 2013). In spite of these innovations in diagnostic procedures for research purposes, in the field of practice the continued use of diagnostic manuals [principally the *International Classification of Disease—10th Edition* (ICD-10; WHO 1992)] has been defended as being 'the only reliable method currently available' (Patel 2013, s.36).

The Palgrave Handbook of Sociocultural Perspectives on Global Mental Health seeks to be inclusive of the diverse views (and associated terminology) employed across the globe to understand and describe aberrant psychological, emotional and/or behavioural states. As such, within the volume varied terminology is used by chapter authors to describe these experiences. Frequently used examples include madness, mental health issues/problems/difficulties, mental illness/disorder and (emotional) distress. Ultimately, the handbook aims to enhance readers' understanding about the diverse ways in which mental health difficulties may be understood and approached across a variety of human situations and worldviews. This includes an appreciation of the need to develop bottom-up/grass-roots initiatives based on local realities. Because chapter contributors come from a mix of different disciplinary backgrounds, a range of epistemic frames are used across the handbook to highlight different ways of knowing, of determining what is worth knowing and of adding to the corpus of knowledge relevant to mental health. Particular emphasis is placed on understanding the role that sociocultural factors play in how mental health difficulties are experienced and responded to. This introductory chapter sets the scene by pinpointing key concepts and events relevant to the emergence of GMH and highlighting some of the relevant contemporary debates that subsequent chapters will explore in greater depth.

Global Mental Health and Social Determinants

In addition to the aforementioned association with transcultural psychiatry, the emergence of GMH has been linked to developments in the field of GH (Patel 2012, 2014).[1] Global health has been defined as: 'the area of study, research and practice that places a priority on improving health and achieving equity in health for all people worldwide' (Koplan et al. 2009, p. 1994). Patel (2014) points out that GH initiatives are guided by three central tenets: (1) reducing disease burden, (2) increasing equity and (3) being global in its reach. The development of GH has served to propagate economic metrics that have been used to highlight the considerable impact that mental health difficulties cause globally. A key example of this was the introduction of the Disability Adjusted Life Year in the *World Development Report: Investing in Health* (Jamison et al. 1993). This metric, which measures the impact of health conditions on morbidity and mortality, led to mental health difficulties being highlighted as a considerable cause of burden in the *Global Burden of Disease study* (Murray and Lopez 1996). Results from the GBD metrics on mental health were used to strengthen the call to address mental health as a worldwide problem in the book entitled *World Mental Health: Problems and Priorities in Low-Income Countries* (Desjarlais et al. 1995). The development of GMH is thus linked to epidemiological enquiry into disease burden and the assumption that mental health difficulties and their impact are standardizable across the globe (Bemme and D'Souza 2014; Baxter et al. 2013). This in spite of the fact that mental health-related epidemiological data are absent or only partial for much of the world's population (particularly the 80% who live in low- and middle-income countries), making it inadequate for planning and policy at a global or local level (Baxter et al. 2013).

Recently, Susser and Patel (2014) have argued that GMH should be regarded as partly distinct from GH, as otherwise mental health difficulties will continue to receive lower levels of priority relative to physical illnesses (including communicable and non-communicable diseases). GMH is also vulnerable to criticisms that have been levelled at GH in recent years, particularly the risk of mental health initiatives being disengaged from environmental, political and economic factors which impact health. These factors form part of the public health concept of 'social determinants' as drivers of

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[1] Readers interested in learning more about the historical context of the emergence of Global Mental Health should consult Bemme and D'Souza (2014), Lovell (2014), and Lovell and Susser (2014).

health inequalities (Marmot 2014) and which were influential in the development of the GH concept. However, social determinants are often narrowed down to proximal or 'downstream' factors such as lifestyles or family structure, with much less focus on broader 'upstream' determinants which operate on a global scale such as economic policies. For example, Richard Horton has suggested that the field of GH has 'built an echo chamber for debate that is hermetically sealed from the political reality that faces billions of people worldwide' (Horton 2014, p. 111). Specifically, Horton (2014) points out that global institutions systematically ignore the *social chaos* in which people live their lives, that is, 'the disruption, disorder, disorganisation, and decay of civil society and its institutions' (p. 111). According to Horton, social chaos can arise from three major sources: armed conflict, internal displacement and fragile economies. The narrow focus of GH may in part stem from the ways in which roles and responsibilities relating to health care have historically been designated. Professionals have tended to operate within the narrow confines of 'vertical' approaches, which have restricted their efforts to working within the competency-specific boundaries of the health sector 'silo'. Whereas health care professionals may feel sufficiently skilled to intervene in medical problems, they may feel less competent at recognizing and addressing factors related to other sectors such as education and criminal justice, let alone national and global policy. An additional complication may relate to the extent to which matters relating to health and mental health can become political issues that are susceptible to the competing political interests of different protagonists. In such circumstances, ignoring 'social chaos' may be a strategic necessity to ensure that the provision of some form of support remains possible, albeit partial. The concern here is that unresolved sources of social injustice and 'structural violence' (Farmer et al. 2006) continue to perpetuate physical and mental health difficulties and limit access to sources of support. It is hoped that the specific inclusion of mental health in the *Sustainable Development Goals* (UN 2015), and initiatives such as the *Out of the Shadows: Making Mental Health a Global Priority* launched by *The World Bank* in April 2016, will be helpful for creating momentum for addressing structural factors that may be serving to limit mental health and wellbeing.

The WHO (2014) has highlighted the need to specifically address social determinants of mental health, and recognition of the influence of social determinants on mental health has been claimed as one of the foundations of GMH (Patel 2012). Kirmayer and Pedersen (2014) argue that GMH initiatives need to place greater emphasis on forms of social inequality and injustice. Indeed, it has been suggested that:

> the hallmark of GMH is to emphasize the simultaneous need for social interventions alongside biomedical interventions as appropriate for the individual. (Patel 2014, p. 782)

However, there has not always been consensus on how a balance might be struck in addressing social, as well as medical, influences on mental health. In addition, efforts to address 'social determinants' have tended to be focused at the *micro* level of the individual and/or the community, rather than tackling wider structural determinants at a *macro* level (Das and Rao 2012). Reflecting this uncertainty, Joop de Jong has expressed concerns that the purpose of GMH is unclear because it lacks a guiding (meta-)theory (cited in Bemme and D'Souza 2012). It is perhaps debatable how much of a drawback this overarching lack of consensus is. On the one hand, it may contribute to the bogging down of GMH advances and initiatives in repetitive arguments over theoretical perspective and appropriate interventions. On the other hand, a diversity of theoretical positions may actually be a stimulating and valuable feature that continually challenges GMH as a field of study and practice to engage with the complex social realities and uncertainties in which people live.

Since the latter part of the twentieth century, mental health services in the West have increasingly professed allegiance to the 'biopsychosocial approach' (Engel 1977). The impetus for proposing this approach stemmed from a concern that the biomedical approach had left 'no room within its framework for the social, psychological, and behavioral dimensions of illness' (Engel 2004, p. 53). Whilst commentators acknowledge that the biopsychosocial approach has made an important contribution to clinical *science*, concerns have been raised about the extent to which the approach has been able to bring about meaningful change in clinical *practice* (Álvarez et al. 2012). Sadler and Hulgus (1990) highlighted that a lack of consideration of the 'practical and moral dimensions of clinical work' (p. 185) means that the *biopsychosocial* approach is largely redundant for guiding specific actions in the clinical encounter. Álvarez et al. (2012) suggested that the absence of concrete guidelines about applying the *biopsychosocial* approach in practice means that it weakens in the face of biomedical approaches. Rather than leading to a holistic, integrative way of addressing mental health difficulties, Ghaemi (2009) raises the possibility that the *biopsychosocial* approach can lead to 'cherry picking' of treatment options, whereby different professionals revert to their specialist training to decide which particular interventions to recommend. This may lead to the emergence of a monoculture of treatment in particular professional groupings. For example, Steven Sharfstein (the former president of the American Psychiatric Association), reflecting on the dominant role that biological approaches to mental health difficulties had assumed in the USA, urged psychiatrist colleagues to:

> examine the fact that as a profession, we have allowed the biopsychosocial model to become the bio-bio-bio model. (Cited in Read 2005, p. 597)

To some extent, concerns about the risk of professional parochialism (among psychiatrists, psychologists, nurses etc.) can be offset by a multidisciplinary team approach that aims to collectively harness expertise in different forms of treatment and intervention. However, in low-income settings such approaches may be limited by restricted resources and limited diversity of professional expertise, resulting in a reliance on more easily delivered pharmaceutical interventions (Jain and Jadhav 2012).

Standardization and Evidence-Based Medicine

Since its emergence, GMH has been the target of a vocal critique, most prominently concerning a perceived dominance of biomedical approaches. Critics have suggested that GMH is a neocolonial, medical imperialist approach that serves to expand markets for psychotropic medication (Summerfield 2012; Mills 2014). Refuting such accusations, Patel (2014) points out that the bulk of interventions evaluated in GMH research have focused on psychosocial interventions. Furthermore, Patel (2014, p. 786) states that it would be 'unethical to withhold what biomedicine has to offer, simply because it was 'invented somewhere else'. Bemme and D'Souza (2014) have contended that the globalization of particular *forms* of intervention has not been a principal concern of GMH. Instead, they suggest that a key feature of GMH has been the dissemination and utilization of particular epistemologies and research methodologies for *evaluating* interventions across the globe. The emergence of the evidence-based medicine (EBM) paradigm (see Guyatt et al. 1995), and the hierarchical approach to research evidence that it espouses, has had a significant impact on shaping standardized procedures for evaluating health interventions. However, Thomas et al. (2007) have cautioned against the assumption that human behaviours and problems are amenable to investigation using the same positivist methods that are applied in the natural sciences. In keeping with this critique, EBM has also been criticized for disregarding the social nature of science and obscuring subjective elements of the human interactions that occur in the context of medicine (Goldenberg 2006).

Greenhalgh et al. (2014) identified a number of limitations in the EBM paradigm as currently practised, including a susceptibility to bias in trials, a failure to take account of multi-morbidity and a tendency to promote over-reliance on 'algorithmic rules' over reasoning and judgement. Furthermore, other commentators have suggested that 'gold standard' EBM methodologies may lack sufficient sophistication for understanding cross-cultural nuances in how emotional distress can be understood and addressed in different contexts (Summerfield 2008; Kirmayer and Pedersen 2014). Kirmayer and Swartz (2013) highlighted the need for the GMH agenda to embrace a 'pluralistic view of knowledge', which can be integrated into empirical paradigms guiding GMH-related research. More recently, the notion of mental health interventions as 'complex' interventions interacting with context to influence outcomes has led to a challenge to the gold standard of randomized controlled studies (Moore et al. 2015). Researchers have called for new methods of evaluation including the use of qualitative methodologies such as ethnography to observe such interactions and unintended effects (Kirmayer and Pedersen 2014; Kohrt et al. 2016). These have been embraced in several studies of community-based mental health interventions in low-income settings across the globe (De Silva et al. 2015). Issues related to the application of EBM to GMH are discussed by Mills and White in this volume.

The 'Treatment Gap' and Community-Based Interventions

The momentum created by the 'call to action' of MGMH coincided with the WHO launching international initiatives such as the Mental Health Gap (mhGAP) programme (WHO 2008, 2010). These programmes have proposed plans for scaling-up services to reduce the burden associated with priority psychiatric diagnoses. In recent years, there has been growing interest in the possibility of developing trans-diagnostic interventions to more generally address the experience of distress, rather than specific forms of diagnosis. This focus on 'distress' and other concepts such as 'subjective wellbeing' reflects a need to broaden the understanding about what constitutes a good outcome for individuals with a lived experience of mental health difficulties (White et al. 2016). The 'Recovery Approach' (Anthony 1993) has advocated the need for psychiatric services to move beyond focusing narrowly on reducing the severity of symptoms of mental illness, to instead move towards themes such as connectedness, hope, identity, meaning and empowerment (Leamy et al. 2011). Research has suggested that the 'Recovery Approach' may have utility across cultural groups (Leamy et al. 2011), and there are emerging attempts to introduce innovations such as 'Recovery Colleges' in low-resource settings. The chapter by Aldersley et al. in this volume provides further reflection on the 'Recovery Approach' and the implications that this has for GMH.

Borrowing language from GH, *The Lancet Series on Global Mental Health* (2007, 2011) and the *mhGAP Action Programme* (WHO 2008) and *mhGAP Intervention Guide* (WHO 2010) draw on the notion of the need to fill the 'treatment gap' (i.e., the gap between the numbers of people assumed to be suffering from mental illness and the numbers receiving treatment). As is the case for burdensome physical health conditions (such as HIV/AIDS and malaria), the urgency for 'scaling-up' services for mental health difficulties has in part been justified on the basis of the moral obligation to act (Patel et al. 2006; Kleinman 2009). The MGMH has been engaged in concerted efforts to mobilize stakeholders and lobby for policy change to address the 'treatment gap'. Vikram Patel has stated that there is a need 'to shock governments into action', and that language should be employed strategically for this purpose (Bemme and D'Souza 2012, para. 24). For example, it is suggested that the 'treatment gap' for mental health difficulties is as high as 85% in low-income countries (Demyttenaere et al. 2004), and that urgent action needs to be taken to bridge it. However, the aforementioned concerns about the poor quality of epidemiological data relating to mental disorders in low- and middle-income countries (LMICs) (see Baxter et al. 2013) will have important implications for the accuracy of estimates of the 'treatment gap'. In addition, critics have argued that the concept of the 'treatment gap' has privileged particular forms of treatment whilst simultaneously failing to recognize the important contribution that non-allopathic[2] forms of support and healing may bring to people living across the globe (Bartlett et al. 2014; Fernando 2014). The inference is that the rhetoric of the 'treatment gap' may well shock governments into taking action, but this action may not be inclusive of the pluralistic forms of support available. Researchers have suggested that pluralism and a multiplicity of treatment options might bring potential benefits for engagement and outcome for individuals experiencing mental health difficulties in LMICs—these themes are explored in more depth in the chapter by Orr and Bindi in this volume.

Jansen et al. (2015) pointed out that the concept of the 'treatment gap' has advocated a particularly individualistic approach to scaling-up services for mental health in LMICs. Fernando (2012) suggested that the burden of

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[2] The term 'allopathy' was introduced by German physician Samuel Hahnemann (1755–1843) when he conjoined the Greek words 'allos' (opposite) and 'pathos' (suffering). It is defined as the treatment of disease by conventional means (i.e. with drugs having effects opposite to the symptoms).

mental health problems experienced collectively by communities is likely to be greater than the sum of the burden on the individual members of that community, especially in the context of 'collective traumas' (see Audergon 2004; Somasundaram 2007, 2010). It is important, however, to appreciate that conceptualization of 'communities' vary across different settings, and there are also marked variations in the degree of cohesiveness in communities across the globe. Campbell and Burgess (2012) suggest that the tendency for GMH initiatives to prioritize interventions aimed at individuals has meant that the social circumstances that can foster improved health have been insufficiently addressed. Bemme and D'Souza (2014) observed that GMH initiatives have narrowly conceptualized 'community' as a method of service delivery. The rationale for community-based mental health care has been closely linked to the ideological shift towards deinstitutionalizing the care of people experiencing mental health difficulties and bringing services closer to where people live. Community care is also proposed as more cost-effective option (Das and Rao 2012; Saxena et al. 2007). Moving forward, there is a need to explore how the concept of 'community' can be promoted as a means of harnessing collective strengths and resources to promote mental wellbeing (Jansen et al. 2015). These efforts should, however, be cognizant of concerns that community action and volunteering in GH and GMH initiatives may take advantage of community workers by relying heavily on their unpaid and demanding work (Maes 2015; Kalofonos 2015). This has implications for both the sustainability and quality of care provided, particularly where there is inadequate investment in ongoing training and supervision.

The 'Global-Local' Distinction

The dichotomy that has been drawn between forms of support that reflect 'local' (i.e., specific to particular contexts) beliefs and practices, as opposed to 'global' (i.e., standardized/universalist) approaches, has been keenly debated in GMH-related discourses. Some have argued that global initiatives for mental health pose a threat to indigenous or local practices (Mills 2014; Fernando 2014). Patel (2014) has warned against the idealization of indigenous (i.e., local) practices, which can include inhumane treatments and practices. Miller (2014) has also argued that a person living in a LMIC 'deserves better than being urged to stay in (his/)her niche in some great cabinet of ethnopsychiatric curiosities' (p. 134).

Bauman (1998) highlighted the way in which what is considered to be 'local' has become organic and porous, as new and ever-evolving associations are formed with 'global' processes. Bemme and D'Souza (2014) point to the relevance of the anthropologist Anna Tsing's (2005) concept of 'friction' for exploring the connections between the 'local' and 'global' in the context of GMH. Friction captures how the supposedly smooth flows of 'universal' ideas, concepts and policies across the globe in reality are slowed down or dragged back on particular terrains; yet at the same time, movement only occurs in the first place through the friction that results from gaining purchase on a particular ground. Thus, the global and the local may hinder each other and/or propel each other forward, but they are never locked in the kind of zero-sum rivalry with which they are so often portrayed. Tsing's approach emphasizes the ongoing co-production of culture in the encounter between universal and particular in 'zones of awkward engagement' (Tsing 2005, p. 4, xi); rather than being opposites, the two are mutually altered in unforeseen ways by this process.

The dynamic interaction between 'local' and 'global' has been captured by the hybrid concept referred to as 'glocalization' (Robertson 1994) or 'glocality' (Escobar 2001), which recognizes the process of syncretization that occurs between local and more global influences. From this perspective, 'doing' GMH would cease to be a debate between the relative merits of adopting universal categories or preserving a pre-existing set of local categories, and would become a question of what further possibilities might emerge from the meeting between the two.

Critical Reflection on Global Mental Health: The Contribution of *The Palgrave Handbook of Sociocultural Perspectives on Global Mental Health*

To avoid the risk of becoming a hegemonic approach, it is important that advocates for GMH engage in critical reflection about the costs and benefits of global initiatives aimed at addressing mental health difficulties. As Patel (2014) states: 'Self-reflection is essential to the improvement of the practice of Global Mental Health' (p. 786). We hope that *The Palgrave Handbook of Sociocultural Perspectives on Global Mental Health* will contribute to this process of reflection, whilst simultaneously pointing to innovative approaches aimed at helping to promote understanding about mental health difficulties across the globe. It places emphasis on the importance of incorporating cross-disciplinary perspectives on themes relevant for GMH. The handbook includes contribution from individuals working in applied contexts (such as social workers, clinical psychologists and psychiatric nurses) as well as academics from the social sciences, law and humanities (such as history and philosophy). As such, the chapters included in the volume draw on a range of evidential sources, including ethnographies, randomized controlled trials, community-based interventions and meta-analyses. Bringing together diverse disciplinary perspectives and methodologies poses many challenges, but we believe that the potential benefits that this can bring for GMH-related practice make this a worthwhile endeavour. It is hoped that this volume will make a constructive contribution to this burgeoning area of enquiry.

Previous texts have drawn attention to the inadequacy of mental health provision in the Global South. This handbook considers GMH in diverse global locations, including critical reflections on how mental health difficulties are understood and treated in the Global North. Although the handbook includes contributions from people living and working in the Global South, as with many volumes in the field, the ratio of contributions from authors in the Global South relative to the Global North is disproportionately low. A number of potential contributors from the Global South who had been approached through our collective networks were unable to commit due to heavy workloads. Some contributors cited a need to prioritize other tasks, whilst others felt unable to commit to producing a contribution within the required timeframe. In addition, there was also the sad death of another contributor. The challenges associated with recruiting contributors from the Global South highlight the ongoing inequalities in terms of training, funding and research expertise in such settings. Whilst many have highlighted the lack of clinical psychiatrists and psychiatric researchers in low-income settings, there are even fewer people in such settings with training and expertise in conducting and evaluating psychosocial interventions and research.

If the institutions, international networks and research expertise that drive GMH are principally based in Europe and North America and perspectives from other parts of the world are not represented, this will have important implications for GMH. For example, a perceived hemispheric disparity in the power base for GMH has led to suggestions that protagonists based in the Global North have the power to project the practices they espouse globally (Summerfield 2013). Commentators, such as Ecks and Basu (2014), have highlighted that in countries such as India, GMH is not a widely recognized field. Similarly, Jadhav (2012) has expressed concerns about the relevance of the field of ‘cultural psychiatry’ in India and who exactly benefits from such disciplines. This is perhaps consistent with the low priority that mental health difficulties are often assigned in LMICs and the differing social, historical and political contexts for the development of mental health services in these settings. Lack of funding and research training as well as the strictures of academic publishing—and its domination by the English language—has severely hampered a representative contribution to mental health research on a global scale. Nonetheless, there are a growing number of important actors from low-income countries involved in GMH initiatives, though to date these remain predominantly psychiatrists. Moving forward, there is a need to find ways to include more practitioners and researchers from the Global South in shaping and leading the GMH agenda, including practitioners from disciplines outside of psychiatry such as social work, psychology and nursing, and researchers from the social sciences and humanities.

The handbook is intended to act as an important resource for students, academics, clinicians, policymakers, non-governmental organizations (NGOs) and 'experts by experience' (i.e., people with a lived experience of mental health difficulties and their carers) who are interested in finding innovative ways of promoting mental health in different parts of the globe. The focus of the book is consistent with key values that we believe should sit at the heart of GMH. These values include the inclusion of experts by experience, the promotion of health and wellbeing, recognition of the importance of contextual factors and structural inequalities and the integration of diverse fields of study.

Part I: Mental Health Across the Globe—Conceptual Perspectives from Social Science and the Humanities

The chapters in Part I set the scene for the subsequent parts of the book. By presenting a set of psychosocially and historically informed perspectives on evolving understandings of mental health, the authors featured here explore different aspects of the concepts, processes and controversies that have, implicitly or explicitly, influenced the developments described above that led to GMH as it is known today. All are concerned with questions of what forms of knowledge those who study, shape or work within the field of GMH should bring to bear in defining or classifying their object(s) of intervention: 'mental health'.

One such form of knowledge is, of course, disciplinary. This handbook as a whole aspires to demonstrate the value for GMH of drawing on the full range of disciplines, including those from the social sciences and humanities. Whilst this interdisciplinary orientation pervades the volume as a whole, three of the chapters in this part, in the course of engaging with the challenges of GMH, explicitly highlight the contribution that specific disciplines—geography (McGeachan and Philo), philosophy (Thornton) and history (Harding)—can make. McGeachan and Philo (chapter 2) review research into space and place in mental health, from mapping of the geographical distribution of mental disorders and factors that might explain the patterns thus identified, to work on the lived experience of particular places associated with mental health issues, or on what makes a person's surroundings either therapeutic or damaging, mentally and emotionally. The word 'global' in GMH is of course intended to make a claim about space—that mental health should be of equal priority everywhere—and this chapter shows the importance of a sustained research focus on space and place for GMH. Thornton (chapter 3), meanwhile, brings the methods of philosophy to bear on a fundamental challenge for GMH: how to incorporate culturally diverse conceptualizations of madness or mental distress into standardized diagnostic systems such as the *Diagnostic and Statistical Manual*. Harding (chapter 4) shows how claims and counterclaims about mental distress and healing produced in encounters between Western, Indian and Japanese bodies of knowledge in an earlier phase of globalization may have implications for understanding equivalent processes of encounter in GMH today.

Both Thornton (chapter 3) and Miller (chapter 5) address diagnostic knowledge in GMH. Whilst Thornton focuses on a specific diagnostic classification, Miller discusses how post-developmentalist thought is impacting on mental health practice. He reviews historical departures in the ongoing effort to reconcile culture and diagnosis, before concluding that careful attention is needed in this debate both to how 'culture' is conceptualized and to the implications of the metaphorical language that the debate's participants employ.

How to act successfully on mental health is another domain contested between different bodies of knowledge. Whilst psychopharmaceuticals form a key component of many GMH initiatives, some remain distinctly wary (Fernando 2014). Jenkins and Kozelka (chapter 8) point to vital benefits that medication can bring in severe mental disorder; however, they argue that these benefits can only be realized if it is used in psychosocially aware ways that rest upon an open dialogue with people using them. Aldersey, Adeponle and Whitley (chapter 6) consider the diverse ways in which recovery might unfold and be understood within different contexts, and what this might mean for the field of GMH as it grapples with how best to improve the lives of people with mental disorder. White and Eyber's chapter (chapter 7) delves into how mental health and its scope might be conceptualized in terms of 'positive mental health' and the notion of 'wellbeing' and explore some of the philosophical and methodological challenges that face scholars and policymakers working within this frame.

Taken as a whole, the chapters in this part show something of the lively scholarship being conducted today, from a variety of perspectives, into how questions of mental health are best identified, classified and approached.

Part II: Globalizing Mental Health—Challenges and New Visions

Following on from the conceptual perspectives in Part I, contributions in this part apply social and psychological theory to interrogate themes central to GMH including stigma, community-based approaches, medical pluralism, violence and human rights. These chapters unsettle the foundational premise of GMH—the presumption that there are universally recognizable forms of mental disorder—and a 'gap' between the numbers of those with such disorders and the numbers of those receiving evidence-based treatment. Several authors, such as Mills and White (chapter 10), and Kienzler and Locke (chapter 14), challenge the primacy of the 'evidence-based medicine' paradigm as currently formulated in GMH, through which measurement of mental disorders and testing of appropriate interventions are conducted using standardized metrics and methodologies, which it is believed allow comparison across settings and populations. Rather, authors in this part emphasize that mental health and mental distress are embedded within the particularities of social and moral worlds and hence call for methods of investigation and evaluation which are sensitive to 'locally relevant evidence' (Kienzler and Locke) and take account of contextually situated experience.

Authors thus call for engagement with community knowledge, values and resources in developing interventions and enhancing resilience. This is in keeping with Kleinman's appeal for an orientation to 'what matters most' [cited in the chapters by Mills and White, and Panter-Brick and Eggerman (chapter 18)] and the 'Recovery Approach' [alluded to by authors such as Orr and Bindi (chapter 15)]. However, Mills and White, Watters, and Orr and Bindi also engage with Burgess and Matthias' (chapter 11) critique of narrowly conceived notions of community in highlighting the diversity within and between what might be classically conceived as community settings and the dynamism of responses to mental illness by community members, families and healers. Furthermore, whilst urging attention to the 'local', these chapters stress the importance of structural factors on mental health including poverty, war and violence, migration and displacement and the ways through which local experience is influenced by wider social, political and economic forces. Such 'upstream' determinants at global, regional and national levels may precipitate mental ill-health and suicide [as discussed in the chapter by Boahen-Boaten, White and O'Connor (chapter 17)] as well as limit the potential of individually targeted interventions.

Whilst the chapters in this part urge attention to the particularities of context, Stavert's (chapter 16) chapter builds on evidence presented in White, Ramachandran and Kumar's (chapter 13) chapter to suggest that despite the different meanings which may be attributed to mental health stigma, discrimination against those with mental disorders, particularly severe mental disorders, seems to be universal. The chapters by Stavert, and by Panter-Brick and Eggerman, both illustrate how culture and communities can be sources of stress and prejudice as much as support, particularly in reinforcing normative cultural and moral ideals which might be unattainable for many in the face of structural adversity and mental illness. Stavert thus suggests that international standards may have an important role to play in protecting the human rights of those with mental illness. However, the extent to which this is the case is dependent on the structures and resources for their implementation, which are likely to be least available to the poorest, illustrating the salience of this part's attention to the impact of 'structural violence' in GMH.

Over the course of this part, GMH is highlighted as providing an important opportunity for reducing ethnocentrism, promoting pluralism and facilitating the reciprocal exchange of knowledge between the Global South and the Global North.

Part III: Case Studies of Innovative Practice and Policy

This part presents case studies of innovative practice and policy initiatives that address some of the conceptual and methodological difficulties with GMH. This expands on a view developed in this book that contextually aware practice and innovations are crucial to enhancing mental health services and outcomes. The part builds on critical insights about GMH made in previous parts and represents a purposeful effort to champion practical outcomes stemming from initiatives developed in partnership with local communities. Contributors were invited to develop case studies around themes relevant to the local settings where the interventions were implemented and to draw links between these settings and the discourses and practice of GMH. The chapters help make visible innovative work that has been conducted in diverse settings in Africa, Latin America, the Caribbean, Australasia, and South and Southeast Asia. The case studies provide opportunities to highlight information about the organizational, policy and sociocultural context in which work relevant to GMH is being undertaken; an analysis of what has made these initiatives innovative and the factors that have shaped their impact; and implications that these initiatives have for GMH policy and practice moving forward.

Three papers specifically address the complexities of 'task-sharing' within GMH. Prashanth et al. (chapter 34) discuss the role of non-professionals in a primary health care programme working with tribal populations in rural Karnataka state, India. They detail long-term engagement with a local community. Cooper et al.'s (chapter 23) discussion of two maternal mental health projects in Cape Town, South Africa, delves into the complex realities of implementing global recommendations on task shifting/sharing. One way that these projects innovate on global recommendations is through experiential and interactive training provided to mental health workers. The authors conclude that implementing task shifting/sharing requires an engagement with local social complexities. Hall and colleagues (chapter 30) describe the *Brain Gain* project in Uganda, highlighting the benefits, challenges and transformative potential of a peer support project operating out of Butabika Hospital, Kampala.

Chapters by Ola and Atilola, and Hickling address school mental health programmes in Nigeria and Jamaica, respectively, arguing for creative and locally specific ways of engaging with schools, children and communities. Through a review of the literature on school-based mental health programmes, Ola and Atilola (chapter 24) argue that the absence of such initiatives in Nigeria provides an opportunity for bottom-up creation and integration of these programmes and culturally specific programmes emphasizing resilience and community engagement. Hickling (chapter 29) traces the trajectory of the Dream-A-World Cultural Therapy approach in Jamaica, which addresses academically underachieving and behaviourally dysfunctional primary school children. The project trials innovative cultural therapies that engage with children's creativity and imagination in impoverished and marginalized communities.

Several chapters address the theme of culturally sensitive research and practice. Discussing the Transcultural Psychosocial Organization Cambodia, Gamble (chapter 22) argues for caution in transposing therapeutic models across contexts and suggests that local concepts of mental health and wellbeing are crucial to developing culturally sensitive services in both the Global South and Global North. Stewart et al. (chapter 31) describe how *commit and act*, an international NGO in Sierra Leone providing training in acceptance and commitment therapy, adapted their approach to the local context. This involved collaboration with trainees to develop locally relevant metaphors and language, and careful analysis of the local context and existing services and policies.

Keys and Kaiser (chapter 28) explore language and communication, cross-cultural measurement of mental illness and the role of structural violence in mental health disparities in Haiti and the Dominican Republic. They argue that effective cross-cultural measurement and communication techniques are important to achieving an equitable GMH.

In a quite different context in New Zealand, Lambrecht (chapter 26) considers how cultural-clinical integration takes place between a client and the therapist in relation to Maori mental health services. The chapter describes Māori models of wellbeing and distress and develops a cultural formulation of a single case. Carey and McDermott (chapter 27) engage in a similar discussion in relation to the health and mental health status of indigenous Australians, which is much worse than that of other Australians. The chapter analyses the historical reasons for this, considering the role of social determinants and highlights the impact of historical trauma on mental health of indigenous Australians.

Two chapters analyse challenges of small-scale community projects and their value for informing GMH practice. Van der Geest (chapter 25) profiles 'Cuenta Conmigo' (CC), who organize psycho-education and peer support for people with a psychotic disorder and their families in Nicaragua. The chapter argues that the lives of people with a psychotic disorder can be improved with a minimal investment. Van der Geest highlights the challenges of sustainable funding and evaluation, which limit the ability of such projects to shape GMH agendas. Chatterjee and Dasroy (chapter 35) discuss Ishwar Sankalpa, an organization addressing homelessness and mental health in Kolkata, India. They describe the evolution of the programme, its underlying values and model as well as challenges. For GMH, Ishwar Sankalpa highlights the importance of collaborative work with communities and experts by experience in developing sustainable interventions.

The theme of mental health and development is addressed in two chapters. Underhill et al. (chapter 21) profile the *BasicNeeds* model for linking mental health and development, which operates in several countries. A central argument is that it is possible to develop an international model that can be applied in different contexts whilst maintaining flexibility to address local particularities. Banerjee and Chowdhury (chapter 32) examine the commercial, governance and local culture factors which shape high levels of self-harm/suicide linked to pesticide consumption in the Sunderban region in India. They argue for psychosocial interventions, international regulation of pesticide companies as part of preventative psychiatry, and new mental health prevention models addressing issues such as gender inequality and domestic violence.

Sarin and Jain (chapter 33) historically contextualize India's recently released mental health policy. Their analysis reveals how the new policy reflects continuities from the past, whilst breaking from this past by drawing on expertise beyond biomedical psychiatry. The chapter discusses reasons for success and failure in health service delivery and the state's approach to policy planning.

The chapters in this part touch a wide range of practice areas. A central theme across chapters is the diverse ways in which local initiatives engage or envision themselves engaging with GMH. The approach to engagement ranges from projects that closely interface with the GMH agenda on one hand to very local, grass-roots initiatives on the other hand. The chapters highlight a key challenge of finding an appropriate balance between the particular and the universal in research and practice in GMH.

Mental health is emerging on the development agenda (Mills 2015; Plagerson 2015) and has been included in the sustainable development goals. However, there are major challenges relating to the types of interventions that may be taken up by donor agencies. As the chapters in the part suggest, there is a value for communities in locally developed or validated psychosocial interventions. Such approaches can contribute to effectively addressing the interface between mental health and development. However, the emphasis within GMH on particular forms of 'evidence' such as RCTs limits the pool of potential interventions and biases towards those developed in Euro-American contexts. As Adams et al. (2016) argue, there is a need to consider alternative forms of accounting within GH that go beyond RCTs if interventions are to have wider community acceptability and relevance. The chapters in this part are a step in this direction.

Concluding Comments

To facilitate further reflection on the material discussed in the various chapters of this volume, we invited three commentaries from recognized experts in GMH that summarize and discuss key themes covered in each of the three parts of the handbook. These were written by Duncan Pedersen (chapter 9), Crick Lund (chapter 20) and Rachel Tribe (chapter 36), respectively, and appear at the end of each part. They bring together some of the key points arising from the broad sweep of GMH topics addressed over the course of this book; at the same time, they indicate how even this only scratches the surface of the considerable issues and challenges that the GMH enterprise raises. Although this handbook may not comprehensively cover all relevant issues, we are confident that it provides stimulating and engaging food for thought for practitioners, researchers, experts by experience, students, policymakers and all others concerned with the field of GMH.

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Part I

Mental Health Across the Globe: Conceptual Perspectives from Social Science and the Humanities

2

Occupying Space: Mental Health Geography and Global Directions

Cheryl McGeachan and Chris Philo

Is there any worth in living? Live not for our own purpose. Instead of being arranged like rabbits, it is better to die. It seems that we are just occupying space (Rupa as quoted in Jadhav and Barua 2012, p. 1361, author's emphasis). This extract comes from the clinical assessment of a 'sad young lady' from Assam in northeast India, diagnosed with dysthymia. After losing her husband in an elephant attack, Rupa has experienced a range of difficulties, including sleep problems, panic attacks and a deep sense of foreboding leading her to feel hopeless and humiliated about her mental health condition and fearful about her future (Jadhav and Barua 2012, p. 1361). These individual concerns of stigmatization and fear coincide with broader apprehension over treatment and confinement of individuals experiencing mental health problems, and are symbolic of a wider conceptualization of mental health and its spaces. Many academic disciplines, such as sociology, history of medicine, critical psychiatry, history, psychology, transcultural psychiatry and geography, have grappled with the different ways in which difference, in relation to 'madness', has been configured as mental illness and traced through a range of sites and spaces across the globe (see Porter 1987; Philo 2004; White and Sashidharan 2014). Many of these pieces have been informed by the work of French theorist Michel Foucault (1967, 2006, see also Philo 1992), who, as Parr (2008, pp. 3–4) has noted, 'outlined a specifically spatial impulse in the historical disciplining of Unreason (as madness) by Reason' in his attentiveness to the

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spatial relations involved in separating and segregating individuals labelled with mental health problems in society. The impulse was arguably productive of a nuanced governmentality which was itself anchored in the development of a specialist science of the so-called mad mind. This emergence of psychiatry developed in a range of specific scientific sites, spaces and places, such as asylums, madhouses and hospitals, and this constricting web of governmentality arguably allowed the legitimization of psychiatric theory and practice through these spaces (see Parr 2008, pp. 1–30; Philo 2012).

There is therefore, undoubtedly, a complex geography to mental health (see Philo 2004, 2005). The geographies of mental health can comprise a number of elements, including the variations in incidences of mental ill-health, the range of locations occupied by the variety of institutions and facilities designed to diagnose and treat individuals experiencing mental health problems, and the different environmental components employed in the creation of therapeutic regimes for those experiencing mental ill-health (Philo 2005). For example, a range of spatial dimensions can be considered through a geographical lens. From the complex inner workings of the mind of individuals to a range of bodies experiencing and treating mental health problems that weave in and throughout medical and non-medical landscapes, geographers have attempted to chart the use and construction of these varied landscapes. The global corporate pharmaceutical machines that ensnare local general practitioner (GP) practices and hospitals in their webs are considered alongside the political action that sweeps across international borders. This fixing and asserting the position of mental health in global agendas and public discourse are simply a few of the spaces that comprise the complex geography of mental (ill-)health. This chapter seeks to highlight the significance of thinking geographically about mental health in a range of ways and aims to demonstrate what a geographically informed analysis of mental health can offer to future debates within global mental health. Beginning with an overview of mental health geography, this chapter will then focus upon four interconnecting strands of the subfield, that of ‘spatial epidemiologies’ and the ‘psychiatric city’, provision and the complex spaces of care, and therapeutic landscapes, to highlight the significance of a geographical approach. A range of examples from the work in mental health geography and beyond will be used to illustrate the different geographical components revealed by these studies, and possible connections of this work to future engagements with mental health geography beyond the Global North will be highlighted. Finally, future challenges and agendas for further critical exploration into global mental health from this perspective will be suggested, particularly in reference to the lack of attention currently given to those sites, spaces and voices in the Global South.

Mental Health Geography

The concerns of 'mental health geography', a subfield of the discipline that takes as its focus the spatial and place-related implications of both the experience of mental ill-health and the provision of treatment facilities and programmes (see Philo 2001), have intersected with the interests of a number of other subfields such as 'health', 'medical', 'cultural' and 'social' geography. Mental illness, its diagnosis and treatment are widely reflected in the literature as an issue that permeates through a range of social, cultural, political, health and medical spheres, and current policy debates relating to the Global South are beginning to consider the places where these spheres overlap in more depth (e.g. WHO 2013). Terminology in such discussions is highly significant as while some geographers remain content to deploy the models and terms of 'mental illness', others prefer to remain sceptical about conventional medical-psychiatric models and seek alternative ways of understanding the wide range of experiences felt by people with mental health problems (see Parr 2008). In doing so, a number of theoretical frameworks have been adopted, including insights from 'anti-psychiatry' (Spandler 2009) and 'post-psychiatry' (Bracken and Thomas 2001), and utilizing a wide range of conceptual vocabularies from phenomenology, critical social theory, psychoanalysis, psychotherapy and political economy (e.g. see McGeachan 2014; Laws 2011). In part to connect with the ongoing attempts to reclaim 'madness' as a politicized identity such as in the recent case of the 'voice-hearing' movement (see Callard 2014), a number of geographers have elected to speak of 'madness' rather than 'mental illness'. Adoption of this term is also partly to acknowledge that as Philo (2005) has highlighted, 'madness' has historically been the predominant mode of understanding different forms of mental difference across different parts of the globe.

In their substantial review, Wolch and Philo (2000) chart three 'waves' of inquiry in mental health geography which are inherently connected to some of the key moves in the discipline of human geography. The first 'wave', the authors suggest, was grounded in spatial science and often employed quantitative methods to investigate the distribution of 'deviant' populations including those experiencing diagnosable mental illnesses. The second 'wave', in contrast, utilized more qualitative methods and remained rooted in social theory, centred more firmly on the social construction of difference. Trajectories towards a third 'wave' are suggested by the authors as harnessing a range of theories and methods to uncover a more nuanced understanding of 'place-specific happenings' alongside more structurally determined 'space-compressing' processes (Wolch and Philo 2000, p. 149). This, the authors note, requires an ability to conduct research across scales, from the micro-scale of individuals' experiences to the macro-scale of external restructuring of corporations and industries. Interestingly, much of the research conducted in mental health geography remains within the confines of the Global North, although this is beginning to be challenged in part due to the increased attention given by the World Health Organization (WHO) and other global organizations to the mental health agenda (see WHO 2001, 2013; Curtis 2010). This absence of research within the Global South in the subfield is both notable and arguably concerning. Through the threads of 'spatial epidemiologies' and the 'psychiatric city', provision and the complex spaces of care, and therapeutic landscapes, the following sections will illuminate the significance of a geographical approach to viewing mental health and signal a way forward for the inclusion of a host of experiences and voices from the Global South currently absent from the literature in the field.

'Spatial Epidemiologies' and the 'Psychiatric City'

Currently, over half of the world's population (54 per cent) live in urban areas with many of the world's largest cities now located in the Global South (UN 2014). This significant spatial reordering of the world's population, which is predicted to continue in this trend (UN 2014), signifies the importance of considering the complex geographies of these spaces. Many urban health scholars are at present debating the current priorities for research into these areas for as Harpham (2009, p. 113) notes 'cities in the South have some of the most striking inequalities in the world: cheek by jowl slums and areas of affluence'. Alongside concerns over physical health in these diverse urban spaces, mental health in the urban areas of the Global North has received considerable attention by mental health geographers (see Curtis 2004, Chap. 7). Throughout the early 1960s and inspired by the pioneering work of sociologists Faris and Dunham (1939) on 'mental disorders' in the city and their influential map of schizophrenia in Chicago, a number of geographers began to reconstruct what can be termed the 'psychiatric geography' of the city (see Wolch and Philo 2000, 139; Nutter and Thomas 1990; Giggs 1973). Many of these studies used a number of statistical methods to detect cross-correlations with spatially referenced data on other variables such as population densities and housing conditions to establish possible causal influences. A key text in this vein was a study by Giggs (1973) on the spatial variations in the distribution of schizophrenia within Nottingham which highlighted a number of close correlations between the incidence of schizophrenia and a large number of social and urban environmental factors such as low social status, high unemployment and low social mobility. This set of work relating to the 'spatial ecology' or 'spatial epidemiology' of diagnosed mental illnesses (see Giggs 1988; Wolch and Philo 2000, 139) produced an interesting array of findings about inner-city concentrations of particular medicalized groupings (especially of schizophrenia) and their socio-economic correlates. Many of these studies paid close attention to the economic factors that aided in shaping many individuals life circumstances to explore the socio-epidemiological correlation between poor mental health and poverty (Murali and Oyebode 2004). However, many studies were careful not to attribute causation exclusively to one factor alone, noting the complexities of interpreting such a nuanced set of conditions (Giggs 1973). This relates strongly to the broader debates surrounding the social construction theory and social drift theory, which continue to investigate and debate socio-economic conditions, urbanization and mental illness (see Hudson 2012). The previous studies tended also, in general, to confirm the earlier findings of Faris and Dunham (1939) with respect to schizophrenia that demonstrated a clear distance decay in the prevalence of schizophrenia with increasing distances away from the city centre, highlighting the significance of these urban spaces for such investigations.

The quantitative rigour of such studies, for example, Gigg's use of factor analysis, offers an elaborate way of describing spatial patterns and cross-correlations. For example, the work of Joseph and Hall (1985) into the concentration of social service facilities, including psychiatric group homes, applied a location quotient analysis to such services in Metropolitan Toronto. The authors argue that the localization data collected could be used in the formulation of placement policies to achieve a more equitable distribution of services. However, despite the detailed spatial patterns produced by the work, such studies do not necessarily succeed in explaining in any great detail the causal mechanisms involved in generating such patterns. Other geographers have therefore attempted to develop their understanding of a city's psychiatric geographies. A range of studies has emerged since the 1980s that investigates the micro level of individuals, many discharged patients or never-institutionalized people, and their interactions with different treatment spaces and landscapes. The use of the urban environment and its role as a source of 'quality of life', 'stability' and 'contentment' was considered (see Smith et al. 1993, 1994) with specific aspects of urban living, such as poor quality and lack of affordable housing, being discussed as a 'stressor' effect on people suffering from enduring mental ill-health (see Kearns and Smith 1993; Kearns et al. 1992).

As the process of global urbanization continues to operate, with all regions expected to urbanize over the coming decades and with Africa and Asia projected to do so faster than all other regions, becoming 56 and 64 per cent urban, respectively, by 2050 (UN 2014), lessons from many of these geographical studies into the 'psychiatric city' can become increasingly valuable. Significant attention in these studies has focused on the correlations between socio-economic indicators such as poverty and geographical indicators of population mental illness (Curtis 2004, pp. 206–207). As the scale of urban poverty is arguably being increasingly overlooked (Satterthwaite and Mitlin 2013), a renewed concentration on these indicators and their correlations could trigger new multi-scalar discussions. Much of the work detailed in this section informed public policy on facility location allocation in relation to mental health in these areas (see Philo 1997, pp. 76–77) and although these models can be highly problematized, particularly in relation to the nature of the services provided, they do shine an interesting lens on the creation and delivery of mental health services in urban areas. As highlighted in the work of Hudson and Soskolne (2012) on their discussions of the disparity on the geography of serious mental illness in Israel, the last decade has witnessed a range of developments in the study of local prevalence rates in mental illness. For example, 28 nations as part of the World Health Initiative have undertaken parallel national psychiatric epidemiological surveys using the WHO Composite International Diagnostic Inventory (WHO-CIDI) (Hudson and Soskolne 2012, p. 898). These studies seek to inform service planning and funding at local levels in order to target resources but, as Wolsh and Philo (2000, p. 149) stress, serious critical consideration must be given to engagement with the policy arena in order to carefully understand the possibilities of the use and misuse of research findings in these debates. For example, many studies have questioned, in different ways the representativeness and cross-cultural validity of the CIDI and other epidemiological evidence, such as the disability-adjusted life year (DALY) measurement. Brhlikova et al. (2011) discuss the serious consequences of uncritically applying epidemiological data in terms of international health care policy making and in reference to depression rates stress that 'single composite measures of depression are highly problematic: they conceal and hide uncertainty, compromise biases and distortion in epidemiological data' (32). This can lead to already scarce resources being diverted and the cultural and social significance of mental health conditions such as depression being hidden and ignored. Laurie (2015) pushes these warnings further in her critique of the DALY measurement, suggesting that the management of human bodies and human suffering is tied ever so closely with economic management and that 'DALY's are complicit in devaluing the lives of certain individuals, by asserting the values of individualism in relation to wider economic gain' (85). The uses and abuses of data in this vein should be continually highlighted and acute attention paid to the policy impacts on people over space and time. Also, there must be increased awareness to see individuals as more than simply 'service users' but as people making difficult decisions in this changing global care climate.

Provision and the Complex Spaces of Care

While concern over where service need is higher in certain places in relation to specific mental health disorders raises important questions about diagnosis and location, a further area of concern in the geographical literature focuses on the tensions and contradictions in attitudes and beliefs towards mental ill-health that can be revealed through an historical analysis of the spaces of care for mentally ill individuals. Often referred to as 'asylum geographies' (Wolch and Philo 2000, 138), which broadly refers to studies concerned with investigating the geographies of mental health services, attention has been given to the origins of mental health care facilities in the 'lunatic asylums' that appeared across Western countries. The asylum often remains a concrete symbol in the landscape of mental health provision and care. For Philo (2014a, n.p.),

> They [asylums] speak of grand medical and moral visions about cure and kindness, albeit a high ground not always reached in practice, and hence they also speak of incarceration, loneliness, abuse and despair. They are painful windows into the soul of a past social order, illuminating what the experts of the time understood to be the divisions between the 'sane' and the 'insane', 'reason' and 'madness', those to be welcomed and those to be shunned.

Arguably, acute attention to the space(s) of the asylum can cast light on the complex geographies of madness and societal responses to it (see Philo 2004). A number of geographers have used various archival sources to reconstruct the location adopted by asylums and hospitals run by a number of (state controlled) bodies and institutions (see Ross 2014). A key body of work in this respect is Philo's (see 2004, 1997, 1989) detailed investigations into 'the spaces reserved for insanity'. Much of Philo's work traces the changing geography of places and spaces associated with madness in Britain through the eighteenth and nineteenth centuries, paying particular attention to the discourses and practices that have created a succession of overlain and often disputed 'landscapes of lunacy' (2004). Questions raised in this type of work address the extent to which such locations—the specific spaces and environments—were shaped by medical, moral or economic discourses, or by a deeper sense of wishing to remove certain 'troubling' and 'frightening' populations from 'sight and mind'. Many of these arguments have been debated in reference to a large number of similar institutions, not specifically designed to house and treat those with mental health problems but which inevitably become bound up with such individuals (Moran 2015). For example, Disney (2015) in his discussions of the complex spaces of orphan care in Russia highlights the range of mental health issues that arise in such spaces and the varied nature of care that is provided.

Attention has also turned to the often abandoned asylum sites themselves. Research has shown the deeply symbolic value still placed on these sites by patients, workers and communities long after the closure of the facility itself. Studies have demonstrated some of the aftermaths of the closure of certain long-stay facilities. Through detailed qualitative work, the significance of old hospital buildings and their surrounding sites has been highlighted (Kearns et al. 2012). In their discussions of patient and staff memories and narratives from the now closed asylum of Craig Dunain in the Scottish Highlands, Parr et al. (2003) highlight the contested nature of such asylum spaces. Their study highlights the notion that these asylums should be considered as more than simply places of medical intervention and treatment, and instead be considered as 'complicated social geographies, heavily invested with symbolic and emotional meanings evoked through the material practices of giving and receiving care' (343; see also Gesler and Kearns 2002). Important connections can be drawn here with work conducted on the design and implementation of contemporary psychiatric care settings in the so-called post-asylum landscape (Wolch and Philo 2000; Curtis 2004). For example, through their research into the perceptions of a newly built psychiatric unit in London, Curtis and colleagues (2009) argue that important questions are raised in these newly restructured landscapes of care as the 'clinical space' is now extended into the community. They discuss the tensions and situations that arise for psychiatric patients and staff when such 'new spaces of [inpatient] care' are being produced, formed and utilized (Curtis et al. 2009) in today's 'risk society' (Moon 2000).

Alongside these institutional spaces and their legacies, geographers have examined a wide assortment of care spaces in the community associated with the process of deinstitutionalization, such as out-patient clinics, support projects, counselling services and home spaces (see Parr 2008; Bondi and Fewell 2003; Bondi 2009). While some have expressed concerns about the sufficiency of such spaces in terms of numbers and quality of service, others have questioned whether the new mechanisms, dispersed throughout diverse communities, amount to a tighter web of 'psychiatric influence' (see Wolch and Philo 2000, 141−143). Examples in this respect include, Dear and Taylor's (1982) Not on Our Street, and Dear and Wolch's (1987) Landscapes of Despair. Dear and Taylor's (1982) work sought to establish the nature, magnitude, and geography of community opposition in Toronto to proposed mental health facilities. In doing so they emphasized the challenges of many communities, notably middle-class suburbs, adopting a 'not-in-my-backyard' (NIMBYist) attitude towards mental health facilities and their users. In contrast, Dear and Wolch's (1987) study more broadly applies theoretical perspectives such as structural analysis and human agency to understand the downstream effects of asylum closure. They survey new spaces of poverty, drug abuse, homelessness, and even reinstitutionalization through the penal and care systems that reinstitutionalized and transinstitutional patients inhabit, such as sober-living homes and other small-scale facilities. A focus in these studies still remains on the urban with relatively little research being conducted on rural areas (for an exception, see Milligan 1999; Parr et al. 2004). Milligan (1999, pp. 234–236) notes that mental health requirements in certain rural populations are poorly understood and advocates a need to develop different typologies of the rural environment in order to aid understanding into the different factors impacting on rural-based individuals with mental ill-health.

A fixation on the differing spaces of care for individuals experiencing mental health problems in a broader changing (deinstitutional) landscape brings into sharper focus the uneven distribution of these health care resources and the fractious politics surrounding their use and implementation (see Curtis 2010; Almog et al. 2004). However, as Saraceno and Saxena (2002) highlight in their discussion of Project Atlas, launched by the WHO in 2000, there is a need to pay attention to the spatial and social subtleties of such agendas. In relation to legislative practices concerning mental health, the authors' note that although the majority of countries in Project Atlas have a law relating to mental health, this is often not comprehensive and 'does not adhere to the international legislation concerning human rights' and is most frequently 'simply mentioned as part of a general health law or a law related to forensic medicine' (Saraceno and Saxena 2002, p. 43). An example of asylum care in India reported in *The Lancet* in 2001 can acutely demonstrate the consequences of such general legislation and highlights the importance of giving such attention to the different spaces, site, and places of asylum care. Kumar (2001) discusses the devastating death of 27 patients that occurred in the village of Erwadi in the southern state of Tamil Nadu on August 6, 2001. In the privately run mental asylum, 27 people were burnt alive, including

11 women, who had been chained to rocks and pillars. The asylum had no electricity or basic sanitation and no doctor was allocated to care for the patients. This was 1 of the 17 similar institutions in the village (Kumar 2001, p. 569). The provision for mental health patients in India is alarmingly scarce, with projected estimates noting that only 100,000 beds are available but over two million are required (this being 2 per cent of the population) and most of these are most desperately needed in urban areas (Kumar 2001, p. 569; see also Davar 2014). This is not unusual as recent reports into mental health service provision in Uganda showed that the only mental health hospital in the country (Butabika National Hospital) had a total of 500 beds (1.83 beds per 100,000 population) (Kigozi et al. 2010). Attention to these asylum (and post-asylum) spaces at the micro (rooms, corridors and equipment), meso (buildings, grounds and fields) and macro (environmental, ecological and locational characteristics) scales (Philo 2014a) provides an important lens into the ways in which these spaces reflect the changing understandings and conceptualization of mental (ill) health across the globe and sheds light on the experiences of those individuals (patients, doctors, families and attendants) caught up within these spaces of care.

Therapeutic Landscapes

As Kearns and Moon (2002, p. 612) highlight in their discussions of a possible new geography of health, the awareness of place as 'an operational "living" construct which "matters" as opposed to being a passive "container" in which things are simply recorded' has an influential effect for discussing the social, political, cultural and historical geographies surrounding mental health and mental illness. In relation to health geography, the notion of landscape has arguably secured an enhanced awareness to 'the intersection of the cultural and the politico-economic in the development of place-specific landscapes of health care and health promotion' (Kearns and Moon 2002, p. 610). One aspect of this development relates to the notion of 'therapeutic landscapes' first introduced in the geography literature by Gesler (1991) in his text The Cultural Geography of Healthcare. Gesler (1993, p. 71) defined therapeutic landscapes as places with 'an enduring reputation for achieving physical, mental, and spiritual healing' and sought to use the concept to further understand interconnections between health, place and identity. Scholars have investigated the symbolic structure embedded within therapeutic landscapes, one of the most internationally prominent being that of the physicians' white coat (Gesler 1991). This coat, for Gesler (1991), has an array of symbolic meanings for different people, such as representing status (economic), privilege and care, and is bound up in the sites and spaces of a variety of medical encounters from the doctor's surgery to the treatment centres in crisis zones. Jones and Moon (1993) argue that attention to therapeutic landscapes can shed new light on the locational and geometric approaches to space and place and in doing so bring to the fore new connections between health, ill-health and place, albeit in complex ways.

The range of landscapes that are tied up with these discussions varies greatly from 'natural and built physical landscapes, social and symbolic environments, and landscapes of the mind, that is, largely or entirely imagined landscapes' (Rose 2012, p. 1381). Although initially a therapeutic landscape was bound to traditional places with healing properties for specific populations, the concept has diversified to include a range of natural and built environments such as gardens (Milligan et al. 2004), public libraries (Brewster 2014) and respite centres (Conradson 2005), all demonstrating the assumption that such a setting can generate the necessary components for some kind of therapeutic experience (Rose 2012). However, within this critical dialogue between different settings of the therapeutic landscape emerges a body of literature that stresses the need to think about the 'counter-therapeutic' and 'non-therapeutic' landscape, the latter arguably perceived as more passive than the former (Jadhav and Barua 2012). In their study of the hidden mental health dimensions of human-elephant conflict, Jadhav and Barua (2012) argue that asymmetric interactions between elephants, people and institutions generate landscapes that are actively 'counter-therapeutic', integrating ecology, culture and the clinic. Important questions are raised here about the construction of therapeutic landscapes and by whom, revealing complex social-political dynamics around the ordering of space for different populations (see Massey 1994).

Wilson (2003), in her research into First Nation Peoples in North America, argues that the concept of therapeutic landscapes is very much:

> a Western conceptualization that does not allow for the incorporation of 'other' ways of viewing the link between health and place. (p. 84)

She notes that research into therapeutic landscapes often ignores the cultural specificity of these landscapes as focus tends to fall upon landscapes that are significant in Western cultures, such as spas and baths (Wilson 2003, p. 84). In her research into how therapeutic landscapes shape the everyday lives for people of the Anishinabek Nation living in Ontario Canada, she explores the importance of culture, for example, systems of belief, and in doing so, she argues that geographical research on health for First Nation peoples can be improved (Wilson 2003, p. 91). For example, Wilson notes that the concept of health in Anishinabek culture is complex and moves beyond traditional biomedical models of health and this is highlighted through a discussion of the medicine wheel. The research stresses that the 'Anishinabek have conceptions of place that differ from our own' and therefore attention to therapeutic landscapes reveals 'the complex intersection of culture, identity and health as manifested in their daily geographies' (Wilson 2003, p. 91). Similarly, Phillips and Rosenberg (2000) argue that much of the work conducted through the lens of health geography tends to be an exercise in 'intellectual imperialism'. Stating that a significant proportion of the research focuses upon English-speaking countries and therefore little space is allowed for exploring how such theoretical arguments, such as therapeutic landscapes, can be applied in developing countries (Phillips and Rosenberg 2000, p. 376). Madge's (1998) work into the therapeutic landscapes of the Jola of The Gambia, demonstrates the important intersections between indigenous medicine and biomedicine and thus highlights the value of

> placing an understanding of health care systems in different places within an awareness of global power relations. (p. 293)

Through the case study of the health care system of the Jola, the author documents indigenous human and ethnoveterinary medical practices, particularly the role of herbal medicine, and highlights the significance of place and cultural context when investigating health care beliefs and practices (Madge 1998).

Gesler (1991, p. 8) argues that, in examinations of health and place, geographers must begin to focus on ethnicity and ethnomedical systems. Wilson (2003) pushes this further by suggesting that more could be done to move away from the continued focus on Western perceptions of health. Instead, researchers should 'acknowledge diversity, difference and the existence of multiple identities and their role in shaping health' (Wilson 2003, p. 85). These debates within the geographical literature relating to therapeutic landscapes cross over into the work of mental health geography. As highlighted in this section, a focus on therapeutic landscapes in these different guises can offer an important critique to the work conducted with mental health geography and open up new pathways of engagement with a range of voices, institutions and experiences bound up with mental health and mental illness that are currently absent in the literature. While work has very creatively used the concept of 'therapeutic landscapes' to discuss the mental health care landscape and different individuals' 'journey' through and within them (see Wood et al. 2013), very little work within mental health geography centres specifically on places within the Global South and the range of people wrapped up in these landscapes. There are many possibilities, therefore, to take these approaches from health geography to the specifics of metal health care and mental health. The following section will offer some reflections on possible points of intersection between discussions of global (mental) health and mental health geographies and raise a number of questions for future consideration.

Discussion: Future Directions

A range of global mental health literature seeks to challenge the assumptions and politics of the current global mental health movement (Tribe 2014) and to seek out solutions in services that are sensitive to the sociocultural context to which they are applied (White and Sashidharan 2014). Jain and Jadhav (2008), in their critique of community psychiatry in India, reinforce the importance of developing culturally sensitive psychiatric theory and clinical services. The prominence of the local in a variety of ways is illuminated, demonstrating the reoccurring tensions between scales of knowledge and encounter. Questions arise over the emphasis placed on local values and concerns in developing mental health programmes and the 'place' of community and community values in designing and implementing appropriate spaces of care. This work correlates with a growing interest within transcultural psychiatry to the mutable nature of cultural identity within the clinical encounter (see Aggarwal 2012; Bonovitz 2005). Paying increased attention to how 'culture frames the self, other, and belief systems during therapy' (Aggarwal 2012, p. 134) brings to the fore the importance of considering a range of spaces, sites and landscapes bound up within the 'clinical encounter' in an increasingly globalized world.

In their report on medical tourism, Buzinde and Yarnal (2012, p. 784) discuss the possibilities of exploring the complex relationship between

> 'the places of human experience and health' through a postcolonial lens. In doing so, the authors' suggest that this would 'contribute to knowledge on the macro-spatial dynamics that characterize the complex core/periphery relationship entailed in the (re)production of therapeutic landscapes of care'. (Buzinde and Yarnal 2012, p. 785)

For many geographical scholars, working within the framework of postcolonial theory allows an investigation into the global politics of difference and a critical examination of taken-for-granted knowledge systems (Briggs and Sharp 2004). In relation to (mental) health, this brings to the fore the complex relationship between 'scientific' medical practices and ways of knowing and indigenous knowledges and alternative forms of healing. Questions arise over the place given to alternative forms of being and of healing in the current international climate of adopting the Western 'scientific' model medicalization and 'cult of the expert'. What space is given to these 'non-scientific' and/or alternative discourses of mental health and mental illness in the construction of new global mental health policy and implementation? Many geographical studies, as demonstrated, are beginning to understand the complexities of asylum and post-asylum care but a global approach paves the way forward for attempting to understand the alternative spaces of care that are provided across a range of scales. For example, what can the micro-geographies of spiritual healing centres and the roles of traditional healers add to an understanding of the different spaces of mental health care? Can this level of analysis aid in bringing to light a whole range of community spaces largely hidden within the currently asylum and post-asylum discussion? Combining postcolonial approaches and therapeutic landscapes could therefore offer geographers and those working within global mental health the opportunity to understand more deeply transcultural spaces of mental health and mental illness.

An increasing body of work on contemporary global health governance has turned to focus upon the 'inequalities often born out of a biopolitical regime that is increasingly driven by the logic of profit and the pursuit of capital accumulation' (Laurie 2015, p. 75). Yet what becomes increasingly clear in these discussions, as noted by Laurie (2015, p. 76), is that the notion of global health can be seen as a misnomer (Heywood 2002, p. 218) as there is an increasingly awareness of the local and unequal articulations of such 'global' phenomena. Questions arise here about the possible sites of resistance and spaces for activism in the mental health area. These debates importantly include both mental health service users and those who wish to stay out of the medical and diagnostic systems. How do these discussions bind together or divide the local, state and 'mental health alliances'? The contentious debates surrounding the right to health strike right to the heart of the 'Global Mental Health' movement as it brings to the fore serious inequalities present over access to care in many countries in the Global South. For a number of scholars, accessing health care that can be seen to be culturally sensitive and locally relevant is key to mental health care in low-income countries (see Jadhav and Barua 2012). Payments for medication and travel to mental health services are increasingly reported to be a barrier in receiving care and are tied up with a series of complex local and societal geographies of stigma and exclusion (Jadhav and Barua 2012). In many ways, '[w]hen health care ceases to be viewed as a public right and it is transformed into a commodity it begins to conjure different "images" to different populations' (Buzinde and Yarnal 2012, p. 785) and further attention can be paid to highlighting the different landscapes of care, healing and incarceration that are constructed in this vein.

Conclusions

As demonstrated through the range of approaches above, investigating the issues of mental health through a geographical lens opens up the possibilities for viewing individual experience of mental health problems as a multidimensional and multi-scalar issue. Returning to the opening quotation of this piece brings to the fore the people and their often painful experiences that are central to these global debates. Rupa may feel that she is simply occupying space, only existing and not living in the world around her, but lives such as Rupa's are never geographically static in nature but continuously cross-cutting into a range of material, social and symbolic worlds at a range of different scales. In increasingly 'insecure' times (see Philo 2014b), research in mental health geography is tightly bound to broader issues such as environmental change and global health. As a call to 'scale-up' mental health service provision and inquiry continues to dominate (see WHO mhGAP 2008), a geographical approach can work in conjunction with the debates in global mental health to highlight the nuances of such an inherently spatial strategy. For example, Curtis (2010, pp. 215–238) calls to geographers' attention the complex question of how mental health might be improved at the population level, placing particular attention on strategies to provide and promote good mental health in the population as a whole, as well as focusing upon treatment of individuals experiencing psychological distress. However, discussions within global mental health also pose a number of important challenges to current geographical research on mental health and mental health care. The current 'silence' of research case studies and work investigating those places that are outwith the confines of Western health care points to a wider failing of mental health geographers' engagement with the cultural specificities of health care and their practices in the Global South. As a range of powerful globalizing forces continue to significantly shape and reshape the places of the world, there is clearly much to be achieved by taking a geographical approach to mental health. However, geographers must also stay alert to the diverse range of spaces, places and people that require attention or there is a danger that the voices and experiences of Rupa and others in the Global South will remain forever silent in the future narratives of mental health geography.

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3

Cross-Cultural Psychiatry and Validity in DSM-5

Tim Thornton

The fifth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual*, DSM-5, puts greater emphasis than previous editions on cross-cultural factors affecting mental illness (APA 2013). Diagnostic criteria have been revised to take account of cross-cultural variation, there is a more specific cultural formulation, and a glossary lists nine 'Cultural Concepts of Distress'. But the DSM does not present a clear view of whether it assumes that mental illnesses are universal and apply across all cultures or whether they can be specific and local to particular cultures. Nor does it give an account of the relation of the cultural concepts to the rest of the taxonomy of disorders or the extent to which they are put forward as valid diagnoses.

The first section of this chapter outlines the ways that cultural factors have been included in DSM-5 (APA 2013). It introduces one particular example: *khyal cap* or wind attacks, a syndrome found among people living in Cambodia. The second section sets out three possible views of the nature of such cultural concepts of distress. On one view, which dates back to the German psychiatrist Karl Birnbaum, an underlying universal 'pathogenic' component is overlain by a variable 'pathoplastic' cultural shape (Birnbaum 1923). This combination suggests the conceptual possibility of two single-factor models in which either factor is set to zero: pathogenic-only and pathoplastic-only. The final section returns to the example of *khyal cap*. On inspection, none of the three models helps accommodate its own incompatible aetiological theory

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with the biomedical view of the rest of the DSM. This suggests that the very idea of cultural concepts of distress fits uneasily with the purported validity of the rest of DSM-5.

Cultural Factors in DSM-5

The fourth edition of the *Diagnostic and Statistical Manual*, DSM-IV, introduced guidelines for a 'cultural formulation' and a 'Glossary of Culture-Bound Syndromes' (APA 1994). The cultural formulation 'supplement[ed] the nomothetic or standardized diagnostic ratings with an idiographic statement, emphasizing the patient's personal experience and the corresponding cultural reference group' (Mezzich et al. 1999, p. 459). The 'culture-bound syndromes' were described as 'locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category' (APA 2000, p. 898).

These new elements in the DSM reflected, firstly, awareness of the need for it to address growing cultural diversity within North America since '[i]mmigrants bring with them their own indigenous patterns and conceptions of mental illness, some of which are structured into cultural syndromes' (Guarnaccia and Rogler 1999, p. 1322). Secondly, the DSM needed to contain cross-cultural material because of its increasing global use.

DSM-5 offers a more extended treatment of cultural factors in psychiatric diagnosis than DSM-IV (APA 2013). Throughout the manual, diagnostic criteria have been revised to reflect cross-cultural variations in presentations of disorders. The discussion of the 'Cultural Formulation' in section III now sets out a semi-structured interview. In the Appendix, there is a 'Glossary of Cultural Concepts of Distress' which describes nine common conditions. The Introduction warns how cultural factors might affect diagnosis and prognosis and thus should be investigated in a cultural formulation (APA 2013, p. 14). The manual suggests that culture can affect any of the following:

- The boundaries between normality and pathology for different types of behaviour
- Vulnerability and suffering (e.g. by amplifying fears that maintain panic disorder)
- The stigma of, or the support for, mental illness
- The availability of coping strategies
- The acceptance or rejection of a diagnosis and treatments, affecting the course of illness and recovery

- The conduct of the clinical encounter itself and how this affects the accuracy of diagnosis, acceptance of treatment, prognosis, and clinical outcomes

The Introduction to DSM-5 also summarizes (in fact at greater length than the later discussion of the cultural formulation in the main text) three distinct ways that culture can impact diagnoses (APA 2013). The single idea of culture-bound syndromes from DSM-IV is replaced by three notions: cultural syndromes, cultural idioms of distress, and cultural explanations (or perceived causes) of illnesses (or symptoms). It is worth quoting the summary in full:

1. Cultural syndrome is a cluster or group of co-occurring, relatively invariant symptoms found in a specific cultural group, community, or context (e.g. *ataque de nervios*). The syndrome may or may not be recognized as an illness within the culture (e.g. it might be labelled in various ways), but such cultural patterns of distress and features of illness may nevertheless be recognizable by an outside observer.
2. Cultural idiom of distress is a linguistic term, phrase, or way of talking about suffering among individuals of a cultural group (e.g. similar ethnicity and religion) referring to shared concepts of pathology and ways of expressing, communicating, or naming essential features of distress (e.g. *kufiingisisa*). An idiom of distress need not be associated with specific symptoms, syndromes, or perceived causes. It may be used to convey a wide range of discomfort, including everyday experiences, subclinical conditions, or suffering due to social circumstances rather than mental disorders. For example, most cultures have common bodily idioms of distress used to express a wide range of suffering and concerns.
3. Cultural explanation or perceived cause is a label, attribution, or feature of an explanatory model that provides a culturally conceived etiology or cause for symptoms, illness, or distress (e.g. *maladi moun*). Causal explanations may be salient features of folk classifications of disease used by laypersons or healers. (ibid., p. 14)

Although the authors distinguish between these different ideas, they concede that the same elements may play a role in all three categories. For example, depression is used as an idiom of distress whether of (1) an illness or pathology, or (2) normal but significant sadness. It is also recognized as a mental illness syndrome gathering together a number of symptoms. Finally, it is taken to be the cause of those symptoms. Just as depression can play the role of syndrome, idiom of distress and explanation, so can other concepts local to other cultures.

Given this complication, although the 'Glossary of Cultural Concepts of Distress' describes nine common cultural syndromes, the concepts described may also play a role as idioms of distress and purported explanations or causes of experiences. The 'Cultural Concepts of Distress' described are *khyal* attacks or *khyal cap* , *ataque de nervios* ('attack of nerves'), *dhat* ('semen loss'), *kufungisisa* ('thinking too much'), *maladi moun* ('humanly caused illness') *nervios* ('nerves'), *shenjing shuairuo* ('weakness of the nervous system'), *susto* ('fright'), *taijin kyofusho* ('interpersonal fear disorder'). Each is related to similar but different concepts found in other cultures and also to the illness categories set out in the main body of DSM-5. *Khyal cap*, for example, is linked to panic disorder.

In the years leading up the publication of DSM-5, much emphasis was placed on the attempt to increase the validity of psychiatric diagnostic categories. The book *A Research Agenda for DSM-V* (Kupfer et al. 2002) which comprises a series of papers on different aspects of DSM-5 starts with this thought:

> Those of us who have worked for several decades to improve the reliability of our diagnostic criteria are now searching for new approaches to an understanding of etiological and pathophysiological mechanisms—an understanding that can improve the validity of our diagnoses and the consequent power of our preventive and treatment interventions. (Kupfer et al. 2002, p. xv)

This passage expresses the worry that whilst work had been done to improve the reliability of DSM-III and DSM-IV, not enough attention had been paid to the validity of the syndromes within psychiatric taxonomy. For that reason, in preliminary discussion, the need for DSM-5 to be a valid taxonomy was widely stressed. That, however, suggests the following question for the 'Glossary of Cultural Concepts of Distress': What is its relation to the rest of the taxonomy, to the other diagnostic categories set out in the main body of the book? There seem to be three general possibilities: (1) The glossary and the main body of the text might both be intended to be valid taxonomies, describing real universal mental illness categories. (2) The status of both could be intended to be the same and all diagnostic categories thought to be culturally specific. (3) The appendix might be intended to have a distinct lesser status, not aimed at validity but rather charting the theoretical errors of other cultures.

The second option is the most conceptually fraught. It requires not just that the rates or prevalence of an illness that can apply universally varies between cultures but rather that the validity of a diagnosis, the very idea of an illness, is in some sense true only of, or for, a particular culture. The paradox of such relativism is that it is unclear that one can assert its general truth. Merely asserting its relative truth does not seem enough. To adopt this view of the main body of the DSM is to adopt a self-consciously ironic or relativist view. One possibility—obviously not taken in DSM-5—is that some diagnoses from the main section belong in the appendix. Perhaps anorexia nervosa is somehow specific to European and North American cultures whilst schizophrenia is universal (Littlewood 1990). So can the aim of cultural sensitivity exemplified in the cultural formulation and the articulation of cultural idioms of distress go hand in hand with the scientific ambitions of twenty-first-century psychiatry? Or are the two ventures somehow in tension?

Khyal Cap

These general questions can be illustrated through one example. One of the nine items in the 'Glossary of Cultural Concepts of Distress' is *khyal cap*, which is described thus:

'khyal attacks' (khyal cap), or 'wind attacks', is a syndrome found among Cambodians in the United States and Cambodia. Common symptoms include those of panic attacks, such as dizziness, palpitations, shortness of breath, and cold extremities, as well as other symptoms of anxiety and autonomic arousal (e.g. tinnitus and neck soreness). *Khyal* attacks include catastrophic cognitions centred on the concern that khyal (a wind-like substance) may rise in the body—along with blood—and cause a range of serious effects (e.g. compressing the lungs to cause shortness of breath and asphyxia; entering the cranium to cause tinnitus, dizziness, blurry vision, and a fatal syncope). *Khyal* attacks may occur without warning, but are frequently brought about by triggers such as worrisome thoughts, standing up (i.e. orthostasis), specific odours with negative associations, and agoraphobic type cues like going to crowded spaces or riding in a car. *Khyal* attacks usually meet panic attack criteria and may shape the experience of other anxiety and trauma and stress or related disorders. *Khyal* attacks may be associated with considerable disability. Related conditions in other cultural contexts: Laos (pen lom), Tibet (srog rlunggi nad), Sri Lanka (vata), and Korea (hwa byung). Related conditions in DSM-5: panic attack, panic disorder, generalized anxiety disorder, agoraphobia, posttraumatic stress disorder, illness anxiety disorder (ibid., p. 834).

The belief that illness can be caused by a dysfunction of a wind-like substance, described using the same word as for wind, seems to be common in parts of Asia (Hinton et al. 2010, p. 245). Khyal is thought normally to flow alongside the blood supply and can pass out of the body through the skin. But the flow can become disturbed, 'surging upward in the body toward the head, often accompanied by blood, to cause many symptoms and possibly various bodily disasters' (ibid., p. 245). It is thought to be caused by, for example, 'worry, standing up, a change in the weather and any kind of fright, such as being startled or awakening from a nightmare' (ibid., p. 246). Local treatments include dragging a coin along the skin, giving rise to characteristic abrasions.

To 'coin', the person dabs the tip of a finger in *khyal* ointment (*preing kenlaa*), a Vaseline-like substance containing camphor and menthol, and then drags the fingertip along the skin to create a streak five or six inches in length. Next a coin is grasped by the fingers and the edge pushed down slightly against the skin at the proximal beginning of the streak; the coin is then dragged outward along the streak of *khyal* ointment. This is then repeated (ibid., p. 271).

Despite the overlap of symptoms with those defined as panic attack, for example, it is clear that the framework of beliefs that surround the conception of *khyal* attack differs from that of biomedical psychiatry. What then is its supposed status in DSM-5? This question calls for a general understanding of the ways in which culture might affect concepts of illness and whether any model can simultaneously aim for validity whilst admitting cultural variation. Thus, the next section will outline three general ways of thinking about the cultural dependence of mental illness categories, the possible role of cultural formulation and hence the different cultural concepts of distress in DSM-5.

Three Models of Cultural Concepts of Distress

A Two-Factor Pathogenic-Pathoplastic Model

One way to understand how culture affects mental illness would be to think of the expression of mental illness as the result of two factors: an invariant endogenous factor and a local cultural appearance: 'pathogenic' versus 'pathoplastic' factors (Birnbaum 1923). The psychiatrist and anthropologist Roland Littlewood stresses the connection between this distinction and the long-standing distinction in psychiatry between the form and content of mental illness.

To deal with variations in the symptoms between individuals, whilst maintaining the idea of a uniform disease, clinical psychiatry still makes a distinction between the essential pathogenic determinants of a mental disorder—those biological processes which are held to be necessary and sufficient to cause it—and the pathoplastic personal and cultural variations in the pattern. Those two are still distinguished in everyday clinical practice by a particularly nineteenth-century German distinction being made between form and content (Littlewood 2002, p. 5).

This distinction needs handling with some care. Littlewood suggests that the pathogenic factor is a necessary and sufficient cause of mental disorder. But the notion of cause suggests a state distinct from the mental disorder it causes. Further, the requirement of a sufficient cause is difficult to attain as causes are only sufficient relative to an assumed causal field (Mackie 1993). The connection to the distinction of form and content suggests a better interpretation is not what causes mental disorder but what constitutes it. The pathogenic factor is then the set of essential properties of disorders, the properties that are necessary and sufficient for a state to count as a disorder. The pathoplastic factor is the contingent variation of inessential properties of the disorder.

Littlewood reports that in the biomedical view of psychiatry, the pathogenic factor is a biological process. In other words, the essential features of mental disorder can be described in biological terms. Such a view fits an influential analysis of mental disorder in general articulated and defended by Jerome Wakefield (Wakefield 1999). According to Wakefield, a disorder is a harmful dysfunction, where function and hence dysfunction is picked out in accordance with evolutionary theory. Evolutionary theory specifies the biological functions of the traits of the human mind and body. Note that the focus on social dysfunction in the DSM is not the same as biological dysfunction. In fact, it better accords with Wakefield's invocation of harm. But central to his attempt to offer a unified account of both mental and physical illness, biological functions include evolutionarily selected mental functions, both cognitive and affective. On this model, the essential or pathogenic properties of a disorder can be described not just in biological terms but, more specifically, as biological dysfunctions explicated through evolutionary theory. (The mental character of the biological dysfunctions which constitute mental disorders will be discussed shortly.) In the case of illnesses where there remains ignorance of biological mechanisms, the idea of a pathogenic factor is an article of faith: a commitment to there being some universal underlying nature to the illness in question.

Although biomedical psychiatry favours a biological characterization of pathogenic factors, other candidates are possible. Consider Louis Sass' account of Schreber's delusions in *Paradoxes of Delusion* (Sass 1994). Schreber was a German judge diagnosed with dementia praecox, now classed as schizophrenia, who wrote a first-person account of his illness, including his delusions, called Memoirs of My Nervous Illness, at the start of the twentieth century.

Sass attempts to shed light on the nature of Schreber's delusions by comparing them to philosophical solipsism.

Solipsism is the view that the only thing that exists in the world is the self of the person who thinks about it. It is expressed in the necessarily first person thought: 'Only I and my mental states exist'. Everything else is merely an idea (for me: one of 'my ideas'). Solipsism is thus a form of idealism—according to which only ideas exist—taken to the logical limit. If everything that exists is merely an idea only the first person subject of thought (for me: 'I') can have those ideas. So only one person exists. This is used by Sass to shed light on the paradoxical quality of schizophrenic delusions:

> [Schreber's] mode of experience is strikingly reminiscent of the philosophical doctrine of solipsism, according to which the whole of reality, including the external world and other persons, is but a representation appearing to a single, individual self, namely, the self of the philosopher who holds the doctrine … Many of the details, complexities, and contradictions of Schreber's delusional world … can be understood in the light of solipsism. (ibid., p. 8)

The elucidation or understanding that Sass seeks isn't merely aimed at one particular delusional experience or even at all of Schreber's experiences considered as a whole. It is meant to shed light more generally on the nature of schizophrenia itself. The reason it can (according to Sass) is that the experiences that characterize schizophrenia derive from a general and abstract feature of rationality:

> [Madness] is, to be sure, a self-deceiving condition, but one that is generated from within rationality itself rather than by the loss of rationality. (ibid., p. 12)

Although a general feature of rationality, Sass himself does not think that the failure within rationality that amounts to schizophrenia is culturally universal. Rather, he thinks that is the result specifically of modernism (Sass 1992). But if, contra Sass, solipsism were not merely the product of recent European culture but rather a standing universal possibility suggested by the abstract structure of rationality itself, then its corresponding disorder—schizophrenia—would be a risk for any rational subject, human or alien, whatever their biology or evolutionary history. The pathogenic factor is, on this model, an abstract feature of rationality rather than a particular biological process or dysfunction.

Whether the pathogenic factor is thought of as a biological or a more abstract feature of rationality, on the pathogenic–pathoplastic model the variation in presentation centres on the pathoplastic factor i.e. culturally invariant pathologies of underlying human nature are overlaid by local cultural variation in how they are expressed. 'Expressed' could carry either of two meanings. First, it might mean that standing possibilities for biological dysfunction or failings of rational subjectivity might be differently prompted or caused by different social or geographical contexts. The idea that mental illness has social determinants is, however, akin to socially caused variation in heart disease rates in different cultures and hardly merits the label 'cultural concept'.

The more interesting idea is that variation in 'expression' picks out the way in which underlying pathologies might be plastic to the different self-interpretations that people in different cultures possess and thus the way the pathologies are experienced and avowed. This would be an example of a cultural idiom of distress in the vocabulary of the DSM-5. But whereas for physical illness, how one understands one's illness might be thought to be an accidental superficiality compared with the real underlying condition (as understood, perhaps, by the medical profession), one might argue that for mental illness its *esse est percipi*: how it is perceived at least partly constitutes it.

On a two-factor pathogenic-pathoplastic model, mental illnesses either are pathologies or are underpinned by pathologies of some sort of universal substrate. The difference between these options is the difference between thinking that the alloy of an invariant underlying pathology and a varying cultural overlay itself comprises what we mean by a mental illness, and on the other hand, thinking that the mental illness proper is identical with the pathogenic factor only.

One might think, for example, that *khyal cap* and panic disorder have the same underlying biological mechanism but that the characteristic way in which, in the former, subjects think of their distress through the conceptual lens of a dysfunction of the flow of wind-like substance is sufficient to mark it off as a different kind of mental illness from the latter. Biological dysfunction is then the common component of two distinct illnesses depending on cultural context. Boorse's (1975) distinction between disease and illness, where the latter is tied to the subject's experience of it, implies a difference in illness in such a case. On the other hand, one might think that the disease is whatever is common to *khyal cap* and panic disorder: the pathogenic factor. It is merely that the appearance that the single disease takes can vary in its experience as illness.

Whichever view is taken of whether the pathogenic factor is the illness or merely the common disease underpinning different illnesses, a two-factor pathogenic-pathoplastic view of cultural concepts of mental illness suggests a particular view of the aim of a cultural formulation in psychiatric diagnosis. It is a way of inferring, from locally divergent symptoms, the universal underlying nature of mental illness. The aim of sensitivity to cultural difference would be to find a way to penetrate beneath it to a common substrate appropriate for scientific psychiatric research.

This seems to be the view of the ex-president of the World Psychiatric Association Juan Mezzich et al. (2009) in their discussion of 'Cultural formulation guidelines' when they say:

> The cultural formulation of illness aims to summarize how the patient's illness is enacted and expressed through these representations of his or her social world. (Mezzich et al. 2009, p. 390)

And

> Performing a cultural formulation of illness requires of the clinician to translate the patient's information about self, social situation, health, and illness into a general biopsychosocial framework that the clinician uses to organize diagnostic assessment and therapeutics. In effect, the clinician seeks to map what he or she has learned about the patient's illness onto the conceptual framework of clinical psychiatry. (ibid., p. 391)

These passages suggest that there is a division between how an illness is enacted and expressed and the underlying biological mechanisms explored by biomedical psychiatry. The former is culturally shaped, the latter is invariant. On Mezzich et al.'s (2009) account, the only positive role cultural factors can then play is as a source of contingent health-promoting resources:

> The aim is to summarize how culturally salient themes can be used to enhance care and health promotion strategies (e.g. involvement of the patient's family, utilization of helpful cultural values). (ibid., p. 399)

In other words, 'culturally salient themes' do not reveal the shape of mental disorders in themselves but can, contingently, be used to promote health because of their effects on how people understand their own illnesses. All this suggests that the underlying view of the role of cultural formulation is determined by a two-factor view. Such a view is, however, merely one of several possible. I will argue that it is a half-way house between two more radical views of the possibilities for cultural psychiatry both of which are versions of a single factor which I will now outline.

Two Single-Factor Models of Cultural Variation: Pathoplastic-Only and Pathogenic-Only

A two-factor pathogenic-pathoplastic model of the nature of transcultural psychiatry requires a distinction between surface appearance and underlying pathology. But it might be that this distinction cannot be drawn. The various ways one might attempt to flesh out the contrast between underlying pathology—for example, as biological or some other underpinning notion of universal human nature—and surface appearance might fail.

Consider the first suggestion for the pathogenic factor outlined above: a biological process which, if Wakefield is right, can be more precisely specified as a harmful dysfunction analysed using evolutionary theory. Drawing a distinction between this and the surface appearance in the way a two-factor model requires might seem unproblematic for some illnesses. It requires that a common underlying biological dysfunction can be identified despite different culturally imposed behaviours or experiences. But in the case of some mental dysfunctions, there may be no principled way of drawing a distinction between an underlying dysfunction and the surface appearance.

To illustrate this, consider the role of biological processes. It seems plausible to assume mental functions and dysfunctions depend, in potentially complicated ways, on human brains. Thus, there may be common biological processes underpinning common mental dysfunctions. But one cannot treat just any shared biological process as the first factor of a mental illness. The biological process has to be a mental process: a failure of a mental function. It is then much less clear how there can be shared mental dysfunctions between different manifestations. The dysfunction may be located only at the surface mental level.

The potential difficulty of dividing between underlying pathology and surface appearance can also be described without talk of mental functions. The philosopher John McDowell argues that human nature can be divided between two distinct levels: biological nature and a 'second nature' that has to be developed through education and enculturation (McDowell 1994, p. 183). A good example is initiation into a first language. Whilst the ability to develop a second nature is contingent on biological first nature, biology alone is not enough. This suggests the possibility of two kinds of mental illness. So-called organic illnesses, such as dementia or alcohol syndromes, are those with a clear biological or first-nature component. But 'functional' disorders are, on this view, disorders only of second nature. In the latter case, it is unclear how to distinguish between the surface appearance of mental illness, its characteristic experiences or manifestations, for example, and an underlying mental process. Mental illness—or at least some mental illnesses—may be features of the surface appearance of our second nature.

If the distinction between the two levels on which the two-factor pathogenic-pathoplastic model depends cannot be drawn, for at least some mental illnesses, that leaves only a single factor. There are, however, two possible one-factor models depending on whether one thinks of illness as all pathogenic or all pathoplastic. A one-factor model need not imply that there is any substantial cultural variation of mental illness beyond prevalence rates. Cultural factors might play a role in causing different rates of illness in different communities without this making the nature of illness in any sense relative to a culture. Using McDowell's vocabulary, this might be because human second nature is itself universal. Or, using Wakefield's model, it might be because the mental dysfunctions that constitute illnesses are universal. A pathogenic-only model holds that illness varies only in external features such as rates and superficial and unimportant local understandings of it. Any apparent deeper variation would be a mark of our ignorance, our misdiagnosis. So a pathogenic-only model has no need for a cultural formulation to extract or excavate the underlying commonalities because they are open to view.

However, following the account suggested in this chapter of the distinction between pathogenic and pathoplastic not in terms of the causes of mental illness but their essential and universal properties, it is possible to articulate a radical pathoplastic-only model. According to this, there might be no shared pathogenic factor between apparently different mental illnesses in different cultures. Cultural variation might go 'all the way down'. Genuinely different forms of mental illness would emerge from different ways of living in different societies. It would thus be a 'category fallacy', in Arthur Kleinman's phrase, to assume that a form of illness found in one culture must, in principle, have application in another (Kleinman 1977).

To flesh this example out, it will be helpful to consider again Sass' account of schizophrenia. The symptoms of schizophrenia are a kind of lived experience of the philosophical theory of solipsism. Sass thus claims that schizophrenic delusion is generated from within rationality itself rather than by the loss of rationality. That basic idea can be used to illustrate both the pathogenic-only and the pathoplastic-only models of cultural idioms of distress. If one thinks that the history of Western philosophy merely illustrates and unpacks conceptual connections implicit in the rationality of any possible thinker—human or even alien—then solipsism is also a standing possibility for anyone and hence, on Sass' account, so is schizophrenia as its lived version. That is the pathogenic-only model. Any apparent culturally determined local variation in the experience of schizophrenia, such as the specific contents of delusions by contrast with invariant forms, would be merely superficial, requiring no great cultural sensitivity to detect. It is the thought that it is merely or trivially superficial which distinguishes this from a two-factor model with its demand for a cultural formulation to penetrate surface features.

If, on the other hand, one thinks, as does Sass himself, that Western philosophy has been driven not merely by the abstract demands of rationality but by historically contingent assumptions about the nature of mind, world and subjectivity, then the temptation towards solipsism will seem to be a local cultural matter. At the risk of oversimplifying Sass' view, if the intellectual movement of Modernism had not existed, then there would have been no such thing as schizophrenia (Sass 1992). This is a pathoplastic-only view because it implies that there need be no common elements to the mental illnesses experienced in different cultures. This is not to say that such illness has no cause. On the gloss offered in this chapter, pathogenic versus pathoplastic concerns what is essential and universal versus what is accidental rather than what causes mental illness.

The pathoplastic-only model is more radical than the two-factor model even though both agree on the need for some sort of cultural formulation. A pathoplastic-only version of a cultural formulation does not enable one to dig beneath surface difference to find underlying common pathologies but would instead be an articulation of the genuinely different ways people can be ill in different cultures. According to it, there are genuinely different forms of mental illness which need have nothing substantial in common across different cultures. The virtues of the validity of a psychiatric taxonomy and its universality diverge.

In fact, sympathy for a pathoplastic-only view of mental illness sometimes seems to go hand in hand with a view that questions the illness status of cultural idioms of distress. For example, Littlewood's anthropological comparison of female overdosing in Anglo-American society with the behavioural patterns of women in 'less pluralistic small-scale societies' looking 'not just at the person involved but at the local meaning of the act in the political context in which it happens' suggests a social function rather than an individual pathology (Littlewood 2002, p. 36). It may be argued that the pathoplastic-only model requires an anthropological stance and that such a stance looks for and tends to find social order rather than individual illness or disorder. But that is not an essential feature of a pathoplastic-only approach. There is nothing inconsistent with the idea that a pathoplastic-only model is a model of illness.

The Status of *Khyal Cap*

The first section of this chapter introduced but left hanging the question of whether the presence in the DSM-5 of the 'Glossary of Cultural Concepts of Distress' implied a kind of anthropological relativism or whether it is consistent with the privileging of a particular cultural standpoint: that of twenty-first-century biomedical psychiatry. The example of *khyal cap* was used to highlight the issue since it involves a distinct view of physiology which includes the flow of a wind-like substance along the blood vessels which normally passes harmlessly out through the skin.

In the case of *khyal cap*, at first sight, no such relativism seems necessary given the definitions of cultural syndrome, idiom of distress, and explanation set out in DSM-5 (APA 2013, p. 14). *Khyal cap* can serve as an 'idiom of distress': the conception of an experience had by a subject. If someone describes their experience as the rising up of a wind-like substance, then that is simply an anthropological fact about the culture. It can serve as a 'cultural explanation' because, again, that is a fact about how a culture explains particular experiences without implicit endorsement of that theory of aetiology by the sufferer. However, by the standards of twenty-first-century Western psychiatry, it can even be described as a 'cultural syndrome' since that is defined as 'a cluster or group of co-occurring, relatively invariant symptoms found in a specific cultural group, community, or context'. If, for whatever reason, the symptoms described co-occur, then it is reasonable to call them 'khyal cap'. In other words, the sincere use of 'khyal cap' by a cross-cultural psychiatrist need not cause any intellectual difficulty.

However, such a reading of the description carries some implications when it comes to understanding the nature of culturally sensitive psychiatry. If the concept of a *khyal* attack is only ever used within the context of what someone from that culture believes—his or her conception of the nature and explanation of their experiences—rather than as an objective description of what is really causing the attack, then that suggests a distinction of kind between cultural concepts of distress and the main elements of DSM-5's taxonomy. Consider the question asked from a biomedical psychiatric standpoint: 'But from what are they really suffering?' The description above suggests a ready answer selected from the list of related conditions in DSM-5: 'Panic attack, panic disorder, generalized anxiety disorder, agoraphobia, posttraumatic stress disorder, illness anxiety disorder'. Such a response suggests that a culturally sensitive psychiatry might be merely a sensitivity to other cultures' errors: the truthful ascription of a false belief about the causes of abnormal experiences.

With that worry in the background, consider the example of *khyal* attack through the range of options explored above. Recall Mezzich et al.'s (2009) suggestion that the role of a cultural formulation is to 'map what he or she has learned about the patient's illness onto the conceptual framework of clinical psychiatry'. This reflects a two-factor model. If applied to this case, the underlying invariant pathogenic factor is whatever is picked out by 'panic attack, panic disorder, generalized anxiety disorder, agoraphobia, posttraumatic stress disorder, [or] anxiety disorder'. The varying local cultural shape is the 'catastrophic cognitions centered on the concern that khyal (a windlike substance) may rise in the body'. Fitting *khyal* attack into the two-factor model does nothing to address the underlying worry, however, because there remains an asymmetry between it and panic attack. From the perspective of the rest of the DSM, the former (i.e. *khyal cap*), but not the latter ('panic disorder'), involves an error about the real aetiology of the condition. Dividing the condition between two factors does nothing to change this perspective.

Nor does it help to adopt the pathogenic-only model. That model presents a stark choice for any putative newly discovered mental illness. Cultural syndromes such as *khyal cap* can have either of two statuses. They are either really other names for universal conditions also picked out by the vocabulary of biomedical psychiatry such as 'panic disorder', or they do not exist. For example, if it is an essential part of the theoretical apparatus of *khyal cap* that it is caused by the rising up of a wind-like substance, then given that on our best account of physiology there is no such substance, then, equally, there is no such condition. Those who self-report it, or its characteristic symptoms, are in some sense in error about their own condition. Again the underlying worry is not addressed.

Could *khyal cap* be understood in accord with the pathoplastic-only model? In rejecting the traditional two-factor model of cross-cultural psychiatry (then generally called 'transcultural psychiatry' [Littlewood 1986a, p. 38]), anthropologically minded psychiatrists such as Roland Littlewood and Arthur Kleinman have implicitly favoured a pathoplastic-only model (e.g. Littlewood 1985, 1986, 2002):

> [C]ulture-bound syndromes are representations in the individual of symbolic themes concerning social relations and which occur in certain personal and historical situations. They articulate both personal predicament and public concerns by means of which women and other depressed categories exert mystical pressure upon their superiors in circumstances of deprivation and frustration when few other sanctions are available to them'. (Littlewood 1985, p. 704)

Such a view plays down the illness status of the behaviour and emphasizes instead its positive social function in addressing an imbalance of power. In his paper 'The culture-bound syndromes of the dominant culture', Littlewood applies the same functional analysis onto diagnoses found in the main sections of DSM. Agoraphobia, for example, is argued to serve an adaptive function for a woman against her husband without open defiance, binding them both together at home (Littlewood and Lipsedge 1986, pp. 262–263).

So it might seem that a pathoplastic-only approach can address a worry about the asymmetric treatment of syndromes in the main body of the DSM and the appendix. If the same pathoplastic-only approach is taken to the syndromes set out in the rest of DSM-5, then it seems that those in the 'Glossary of Cultural Concepts of Distress' have the same status. But there is a cost to this. It is not that an ironic attitude to the cultural concepts is avoided. It is rather that it is generalized to include diagnoses favoured by biomedical psychiatry for example: agoraphobia, anorexia nervosa. In any case, debunking psychiatric syndromes set out in the main body of the DSM by arguing that they are really meaning-laden adaptive strategies rather than genuine pathologies may be plausible in some cases (perhaps attention deficit hyperactivity disorder (ADHD), personality disorder, depression following bereavement), but it seems implausible across the board. A globally ironic attitude to every mental illness syndrome is a high price to pay for affording cultural concepts equal status.

However, as was argued above, a pathoplastic-only approach need not deny the pathological status of conditions in favour of adaptive social functions. It need not take a debunking attitude to claims of local pathology. It could be taken to chart genuinely different ways of being ill resulting from being in a different culture. An anthropological investigation could be of different forms of illness. On a pathoplastic-only approach, this requires some universal concept of illness in general whilst denying that illnesses need be universal. Jerome Wakefield's analysis of illness as harmful dysfunction provides one such universal standard (Wakefield 1999). Bill Fulford argues that illness is a value-laden failure of 'ordinary doing' (Fulford 1989). Either of these general accounts of the concept of illness could serve for an anthropological investigation of cultural variations in forms of illness in the context of local values. Behaviour which amounts to agoraphobia in the UK might involve no failure of ordinary doing in a culture in which a subpopulation such as women is not expected to venture outside, for example.

Despite the possibility of a pathoplastic-only approach to local conceptions of pathology (rather than socially adaptive functions), this does not help in the case of *khyal cap*. The problem is that it involves not just a description of a local failure of function or action. In fact, the possibility of construing it as a variant of panic attack or disorder suggests a continuity of the kind of failure of function or action that it embodies with those recognized in the main body of the DSM. Rather, the main difference lies within the local aetiological theory. But this is not merely different from but rather incompatible with the view of the body contained within biomedical psychiatry. Espousing both a traditional biomedical view in the main body of the text and an incompatible view in the appendix threatens the validity of one or the other. They cannot both be set out as true accounts.

Conclusion

One of the criticisms of Western psychiatry has been its cultural narrow-mindedness, reflecting a particular sociocultural perspective but without realizing this. Littlewood, for example, argues that psychiatry has often assumed that experience of mental illness in America and Europe is more purely pathogenic, whilst other cultures embody a kind of error: ‘a poor imitation of European forms’ (Littlewood 2002, p. 10). The fact that DSM-5 has more explicitly addressed the nature of cultural idioms of mental distress than previous editions might suggest progress has been made in addressing this criticism. Despite this, however, there remain tensions within the DSM in accommodating the cultural concepts of distress. As the example of *khyal cap* illustrates, they can be framed in local aetiological theories or local accounts of physiology, which are incompatible with the views of biomedical psychiatry expressed in the main body of the text. None of the three models described here of the relation of disorder to culture helps.

To summarize: on a pathogenic-only view, cultural idioms of distress accord with DSM categories, correct or augment them, or embody errors. But the model rules out the idea of cultural variation. The traditional two-factor pathogenic-pathoplastic model allows that *khyal cap* may contain a genuine pathogenic core, which reflects diagnostic categories from the main body of the DSM, but the difference in physiological theory corresponding to the idea of wind flow along the blood vessels is a local, pathoplastic error. Whilst it is true that those self-ascribing *khyal cap* are distressed, it is not true that this results from dysfunction of an inner wind. The more radical pathoplastic-only model suggests the possibility of genuinely distinct conditions in virtue of different conceptions of flourishing, or ordinary actions, or societal functions (depending on the view taken of the concept of disorder). Such a view contains a variety of relativism. To be ill is relative to the practices or functions or actions of a local culture. But there is no reason to think that the truths of human physiology are in that sense relative to local cultures. And hence the pathoplastic-only model is no help in accommodating *khyal cap*.

This result is, perhaps, unsurprising. Although these cultural concepts of distress are flagged in the Introduction and discussed in the main body of DSM-5, their articulation and description is restricted to an appendix. They do not form a part of the taxonomy of mental illnesses proper whose aims include validity. Discussion of the abstract models of the 'Glossary of Cultural Concepts of Distress' does, however, suggest two different approaches to the relation between future psychiatric taxonomies and anthropological investigation. On a pathogenic-only or a two-factor pathogenic-pathoplastic view, a completed psychiatric taxonomy would contain a finite number of underlying universal conditions, overlain, according to the latter view by different culturally imposed appearances. But on a pathoplastic-only model, there are as many possible illnesses as there are ways of being unable to take part in local ways of life or local conceptions of flourishing. This challenges the idea of universal diagnostic categories. A compendious version of the DSM would have to chart conditions that, by virtue of their local cultural origins, would not be applicable globally. Given that the arguments for or against any one of the different views of cultural concepts do not produce clear results, this remains a live possibility.

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4

Historical Reflections on Mental Health and Illness: India, Japan, and the West

Christopher Harding

At first glance, placing India and Japan alongside one another in an exploration of Global Mental Health seems an odd choice. Japan is one of the world's wealthiest and most advanced societies, with standards of medical practice and provision to match. Despite remarkable economic growth since the 1990s, India continues to mark a contrast: an up-and-coming global power, but one whose serious and seemingly intractable inequalities of wealth and medical treatment—including mental healthcare—have led to its becoming a key target for intervention by emerging Global Mental Health networks from the WHO's Mental Health Global Action Program to the Movement for Mental Health.[1]

What Japan and India share in common, however, along with broad swathes of Asia and Africa, is a combination of many centuries' worth of philosophical reflection on psychological distress with recent and to some extent parallel encounters with the West, particularly in the late nineteenth and early twentieth centuries: the latter's economic, military, and technological power; its forms of knowledge; and its paradigms of health, illness, and treatment. Although this cultural contact with the West took place against two very

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[1] See Patel and Prince (2010). On some of the concerns raised about these initiatives, see Campbell and Burgess (2012).

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different historical and political backdrops in Japan and India, we see five remarkable sorts of similarities, detailed below, which are broadly instructive when it comes to the dynamics of modern and contemporary global mental health. Together, they suggest the value of historical approaches in understanding Global Mental Health in specific national contexts today; they show us the need to navigate with care between cultural essentialisms and inappropriate or politically loaded—even neocolonial (Fernando 2014)—attempts to universalize when it comes to (supposed) psychiatric conditions, and they encourage us to look not just to institutional dynamics and narrative, but to the operation of (micro)local initiatives and even individuals in catering for people and problems left behind by the dominant policies and paradigms that globalization, and national responses to, it throw up.

First, there were dilemmas in India and Japan over what to do with Western categories of knowledge and practice, together with the institutions and forms of expertise that gave them concrete and culturally influential reality: religion and philosophy, science and medicine, the 'psy-disciplines'—psychiatry, psychotherapy, and psychology—and governmental health policy.[2] Indian and Japanese intellectuals had to decide whether to try to make the best of imperfect overlaps between these categories and their own rich cultural traditions or to establish alternative modern categories more firmly rooted in those local traditions. Where Japanese Buddhism was concerned, for example, ought it to be regarded as a religion, a philosophy, a psychology, or a form of psychotherapy—even a theory of how the human nervous system works? It seemed to be all of these things, with no *single* label possible or appropriate. Dilemmas such as these had major implications for how emotional distress would be interpreted and addressed in different parts of Indian and Japanese societies.

Alongside a problem of categories ran broad-spectrum cultural nationalisms, whose central tenet was this: for all the cultural and technological achievements of the West, the intellectual traditions of India and Japan were generally of longer duration, with a great deal to contribute to global scientific and religious discourse—and these contributions ought to be facilitated as far as possible. When it came to establishing the conceptual, institutional, and legal bases for modern mental healthcare in these two countries, there was significant disagreement as a result between those who sought modernity via the import of Western medical and therapeutic ideas and those whose priority it was instead to explore and promote—at the very least, not to

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[2] My use of 'psy-disciplines' is inspired by the work of Nikolas Rose (1999), who has popularized the use of the term in English.

discard—relevant insights from their own traditions. ‘Relevance’ was often rather forced, with modern medical rationales wielded in the defence of old practices—where, for example, sympathetic Japanese psychiatrists discussed the centuries-old method of bathing mentally ill individuals under waterfalls in terms of ‘hydrotherapy’. It was also not uncommon for ‘tradition’ here in fact to be a significantly revised—freshly edited and rationalized—form of what had actually pertained in the pre-modern past (Sharf 1993). Such distorting effects were compounded by essentialist claims made about the particular mental or spiritual capacities of Japanese and Indian women and men. If Western colonial-era commentators liked to pronounce upon physical and emotional ‘types’ across the colonized world, the better to mark themselves out as superior in various ways—a trend highlighted in Edward Said’s notion of ‘orientalism’ (Said 1978; Sinha 1995)—then a good many influential Japanese and Indians developed ‘auto-orientalisms’ in the late nineteenth and twentieth centuries, with long-lasting implications for the perceived validity in Asia of Western mental health categories and treatments.[3] These cultural nationalisms of the pre-1940s period ended up feeding into interest in transcultural psychiatry and disillusionment with strictly biomedical models of mental health and illness well into the late twentieth and early twenty-first centuries.

A third shared aspect of the Indian and Japanese experiences has been a tendency to point to the emotional and psychological ill health of individuals and whole communities as ‘proof’ of the debilitating influence of Western norms. From hyper-individualism and hyper-rationalism to materialism and a crippling work ethic, Asian commentators have claimed that deleterious social trends in their countries are the result of the wrong sort of cultural exchange with Western societies and have used rising rates of mental illness or antisocial behaviour—from neurasthenia and depression in Japan to violence among the young and between religious communities in India—as evidence of the pathological extremes that such trends have reached (Wu 2012; Kitanaka 2011; Gandhi 1909/1997). As with cultural nationalism, a set of processes set in train in the pre-1940s era continues to reverberate into the present day: concepts of mental health and illness still serve as proxies for national debates about shifting social and behavioural norms, frequently with negative reference to Western or global trends and pressures. The debate around *hikikomori* (acute social withdrawal) in Japan is but one of a range of recent examples of such debates (Goodman et al. 2012).

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[3] On ‘auto-orientalism’, see Befu (2001). See also Dale (1986).

Fourth, governments in both Japan and India, up to at least the 1940s, were relatively slow to take a serious interest in mental health legislation and the provision of public services. State-building priorities lay elsewhere, with the result that pioneering figures who blended entrepreneurship with an appreciation of local healing and religious traditions enjoyed more cultural and commercial space than they might otherwise have done. The roots of 'unregulated private markets' in major contemporary Indian cities like Kolkata (Ecks 2013) can be traced back to this earlier period. And while the reach of Japanese legislation, doctors, and law enforcement is greater than in most parts of India, nevertheless one sees a continuation into the present there too of forms of psychotherapeutic healing such as Morita therapy and Japanese psychoanalysis whose early success stemmed in large part from people's inability to access—and, often, their mistrust of—mental health facilities provided by the state.

Finally, Indian and Japanese family structures and norms of social interaction gave rise to significant areas of disagreement with forms of mental healthcare seemingly premised upon Western-style individualism and relationships. Notable areas of controversy arose where such norms came up against the extended family system in India and the particular roles played by fathers and mothers in Japanese families.

The aim of this chapter is to trace the emergence of these key themes in India and Japan's modern encounters with the West, looking first at early Indian and Japanese cultural forms but focusing for the most part on the period from the latter half of the nineteenth century onwards.

Psychological Health, Illness, and the Self in Indian and Japanese Cultures

Throughout Indian and Japanese traditions, ideas about how the human self is constituted—as theorized from outside and as experienced in the first person—have been used to discuss dimensions of life which, in much of the contemporary world, tend to be separated out into psychology, religion and philosophy, ethics and morality, self-cultivation, social status, and medicine. Central to these traditions has been the idea that the human body and self is composed of various elements and qualities, whose successful balance facilitates good 'health', including mental health, not just in a relatively narrow functional sense but involving progressive stages of self-realization and moral development. This is connected in turn with a view of mental illness less as a new entity that appears in the life of a person (the 'ontological' view of disease) and more as a change in the balance of these existing elements or qualities [the 'physiological' view (Lock 1980)]. Many aspects of such key explanatory frameworks as Ayurveda, tantra, and kanpō have made the journey from straightforwardly literal truth claims to figurative forms of speech that retain serious therapeutic utility—often with the literal, the unknown, and the functional-figurative continuing to interlock. But the idea remains influential in India and Japan that mental health, on the one hand, and thriving in a spiritual or moral sense, on the other, are not notions from separate worlds, requiring entirely distinct interpretive frameworks and/or professional approaches. Rather, they are points on the same continuum. This, of course, is a mixed blessing: many will see opportunities here for holistic prevention and care, while others will be reminded of the 'bad old days'—not so long ago, even in parts of the world that regard themselves as advanced—when mental illness was understood as a matter of supernatural forces and sin, of guilt and punishment.

The oral and written tradition in South Asia that the modern world later came to know as 'Hinduism' is rooted in a series of Sanskrit texts known collectively as the Vedas ('Veda' means 'knowledge'), the earliest parts of which are thought to have been composed between 1200 and 1000 BCE. In these, we find the earliest evidence, in the region, of serious reflection upon human psychological distress, including discussion of disturbances of the emotions, 'insanity' (*unmada*), and the possible role played by malevolent spirits. A consideration of *bhuta-vidya*, or 'knowledge of evil spirits', formed a part of a text called the Charaka Samhita, which became central to one of India's great medical traditions, Ayurveda, over the next centuries. In Ayurveda and the esoteric tantra tradition, the human self is composed of a number of different bodies: alongside the gross physical body, there is a 'subtle body' concerned with senses, energy, and the outward form of the mind. It is through the workings of this subtle body that one's energies and hence one's state of mind can be guided positively towards self-realization—or can end up so disordered that one descends into insanity via the generation of a *bhuta*, a malevolent spirit. Among the available remedies in these traditions have been changes in diet, herbal mixtures, hot-water baths, and massages, alongside ritual and devotional practices.

Probably the best known and philosophically one of the most significant reflections upon human distress in later classical Indian literature is the *Bhagavad Gita* (The Song of the Lord), which dates back at least as far as the early centuries BCE. The Gita was the outcome of a period of Indian life and thought in which close attention was paid to the inner spiritual and psychological conditions of ordinary men and women, including the phenomenon of desire—in the sense of attachment to things, people, hopes or fears, and its possible causal role in both the way an individual life plays out and the nature of future cycles of rebirth (Wagner et al. 1999). On the eve of a great battle, Prince Arjuna shares his anxieties about the imminent hostilities and about his own life with his charioteer, a figure who is gradually revealed to be Lord Krishna, an incarnation of Vishnu. Krishna describes to Arjuna, in return, various practical means by which he might cope with desire and work to integrate aspects of himself—including the contemplative intellect, the discursive intellect, the passions, and the senses—towards the realization of his true, immortal self.

Dealing with the senses and the passions is no easy task: as Krishna points out, human beings are at war with themselves much of the time. Yet it is a vital task. At one end lies peace and integration and at the other, madness:

> When man dwells in his mind on the objects of sense, attachment to them is produced. From attachment springs desire and from desire comes anger.
>
> From anger arises bewilderment, from bewilderment loss of memory; and from loss of memory, the destruction of intelligence and from the destruction of intelligence he perishes.
>
> —*Bhagavad Gita*, Chap. Two

A number of Indian psychiatrists have described Prince Arjuna's encounter with Lord Krishna as a model psychotherapeutic exchange (Trivedi 2000; Thara et al. 2004; Gautam 2009), while another classical Indian text, the *Ramayana*, is said through its account of the relationship between Rama and his wife Sita to be a study in interpersonal and intrafamilial relationships. J.K. Trivedi has pointed out that the enormous role of epic stories such as the *Mahabharata* (of which the *Gita* is a part) and the *Ramayana* in shaping selves and relationships in India, over the centuries, means that they remain indispensable as sources of anecdotal insights and inspiration in psychiatric and psychotherapeutic contexts. One of India's leading post-independence psychiatrists, N.N. Wig, has been particularly influential in calling for more mental health professionals in India to make use of Indian mythology as a therapeutic resource (Wig 2004). The Swiss psychiatrist Erna Hoch highlighted the need for something similar during her time in India—especially in her work with illiterate rural Indian populations (Hoch 1977). And most recently, C. Shamasundar has shown how the storyline of the *Ramayana* contains illustrations of 'the elementary principles of simple counselling in a step-by-step manner' (Shamasundar 1993). There is perhaps a tension here, between counselling and psychotherapy seeking to offer widely understood points of reference—reaching far beyond the Indian equivalent of the middle-class Western clientele for whose benefit Freud intended his use of Greek culture—and serving as yet another means by which cultural nationalist agendas are furthered (see below).

Ayurveda, tantra, Buddhist and Jain systems of philosophy, and medicine ran alongside Siddha medicine in south India and the Graeco-Arabic medical system known as Unani in the north from the twelfth century, joined by new ideas and practices brought to India by Portuguese, French, Dutch, and English traders and missionaries in the sixteenth and seventeenth centuries. Of particular significance, as we shall see, was the steadily expanding control of the English East India Company over large parts of the South Asian subcontinent from the mid-eighteenth century onwards.

Japan's medical and mental health traditions owe as much as India's to successive phases of archaic globalization. The earliest folk beliefs and practices, about which relatively little is known, came to be designated 'Shintō' (the Way of the Gods) after the sixth century CE in order to distinguish them from Buddhist ideas making their way into Japan from China and Korea. Shintō seems to have regarded goodness and health as natural human states, put at risk when people give in to temptations or when they open themselves up to visitations by evil spirits or pollution via contact with certain substances, including corpses and blood. Remedies were the preserve of shamanistic healers, who recommended herbal and ritual cures alongside the use of natural hot-spring baths. Hot springs (*onsen*, in Japanese) have been a constant feature of Japanese culture down to the present day, and in this earliest period prior to the large-scale influx of Chinese culture, they were specifically thought to be cleansing in both ritual and bodily senses. As such they were associated with the cure of psychological distress well into the twentieth century (Hashimoto 2014).

From the sixth century CE onwards, Chinese medicine made its way into Japan, bringing with it Confucian connections between a person's social duties and his or her maintenance of a healthy body and mind—such that ill health might be attributed to failings in one's diet, behaviour, sleep, or social relationships (Lock 1980, p. 29). Kanpō, as Chinese medicine became known in its Japanized form, shared with Ayurveda a concept of energy—known as *ki* in Japanese—flowing around the body via similar routes to the blood as well as through channels known as meridians. Disruptions to this flow could have environmental, social, or emotional causes and were thought to be responsible for the emergence of full-blown disease, including of the mind. Treatments included herbal medicines, acupuncture, massage, and respiratory therapy.

Unlike Shintō, kanpō did not recognize such a thing as spirit possession. And whereas Shintō treatments tended to be powerful and dramatic, their kanpō counterparts worked at a gentler pace. Many Japanese continue to prefer kanpō over allopathic medication because of what are regarded as the former's gentler mechanisms of action (Lock 1980, p. 45; Daidoji 2013, pp. 60–62), although in general Japanese people since the early modern period have tended to mix and match medical frameworks and expertise as availability, finances, taste, and perceived success rates dictated.

Particularly significant for the development of Japanese thinking about medicine and mental health were early modern contacts with Dutch medical science. So-called Dutch studies, or *rangaku* [*ran* from 'Oranda', the Japanese word for Holland; *gaku* meaning study], took their place alongside two rival kanpō schools (*goseiha* and *kohōha*) to dominate medicine in Japan by the eighteenth century (Daidoji 2013). One of the major concepts in mental health by the eighteenth century was *utsushō*, a kind of depression, a notion that entered Japan from China and later came to be called *kiutsubyō* [constraint-of-the-ki illness] or simply *kiutsu*. Popular literature referred to this condition as one of 'gloomy mood, lack of energy, and social withdrawal' (Kitanaka 2011). At least one doctor of the early eighteenth century, Gotō Konzan, thought he detected a general rise in *kiutsu* in the population, which he attributed to altered flow of *ki* in the bodies of people who had exchanged physical movement in times of war for (mere) intellectual activity in times of peace. Junko Kitanaka links this to an emerging proto-capitalist work ethic in modern Japan and notes that for would-be intellectuals 'depression' offered a certain social cache while for the other prototypical *utsubyō* patient, the wealthy idler, the connotations were probably less positive (Kitanaka 2011).

The idea that *ki* constraint was often a symptom of moral failure gave rise to treatments for emotion-related disorders that resembled a highly judgmental form of talking therapy. In 1821, a doctor by the name of Wada Tōkaku employed the following bedside manner with one of his patients, who had been unable to get out of bed for two years following the deaths, one by one, of all eight of her children:

> *Stop wailing and moaning, you fool and idiot! Kiutsu like yours never happens to those who have to earn their daily rice … if you were to ask me about the cause of your disease I'd say it is nothing but smugness. You have completely forgotten that you are indebted to your ancestors.* (Daidoji 2013, p. 67)

Wada's therapy marked a radical reinterpretation of the patient's condition, which she had previously been encouraged to blame on physical causes. The appeal instead to the patient's own moral state—not least her forgetting of what she owed to her ancestors—was apparently successful: the patient apologized and left her bed.

It was around this time that a process of metaphorization seems to have taken place. *Ki* came to be seen less as a movement of energy within the body and more as a way of talking about subjective shifts in mood: various new phrases emerged in Japanese, such as *ki ga kiku* [lit. the ki/spirit is functioning well], meaning to be smart or thoughtful; or *ki ga tsuku* [lit. the ki/spirit has become attached], which means to notice something (Kitanaka 2011, pp. 37–38).

Late Nineteenth and Early Twentieth Centuries CE: State Power, Cultural Nationalism, and Diversity in Healing Practices

Psychiatry and the 'psy-disciplines' more generally—including psychology and psychotherapy—took on somewhat unexpected roles in Japan in the final decade of the nineteenth century, as a new generation of modernizing leaders worked to separate ideological wheat from chaff—where both Japan's cultural inheritance and new ideas and models available from Europe and the United States were concerned. Japanese Buddhism was held partly responsible for Japan's humiliating scientific and technological malaise, while sorcery, magic, shamanism, and traditional forms of medicine were treated to similar levels of official hostility. Western science and medicine were championed both as replacement frameworks for understanding the world and as the ideal means of rationally critiquing the beliefs that most Japanese still held. Some of the earliest work carried out in Japan by newly trained psychiatrists and psychologists involved researching popular psychology and demonstrating to people that belief in demons, ghosts, and monsters was at best outdated and at worst a kind of pathology.

To the extent that 'demonstration', here, implied the primacy of empiricism and objectivity in deciding upon the legitimacy of diagnostic categories and methods of treatment for mental illness, it remained just one among a number of competing rationales in the turn of the century Japan. Objectivity was not (yet) what Daston and Galison refer to as a primary 'epistemic virtue' in Japan (Daston and Galison 2007), at least not across great swathes of the rural and non-elite urban population. Equally influential was what one might call a 'value orientation', whereby the ability of a given diagnostic/

treatment system meaningfully to contextualize distress was fundamental to its legitimacy. This meant somehow locating health and illness within the prevailing common sense account of reality to which Shintō, Buddhism, and Confucianism had contributed over centuries. Western-educated Japanese who thought highly of the historical achievements of Japan's various Buddhist sects sought therefore to relativize Western knowledge—to put it in its place, rather than accept the universalist, totalizing claims that it made for itself. Pioneers like the Buddhist Enryō Inoue (1858–1919)—who invented the term *seishin ryōhō* (psychotherapy)—learned to speak the language of official and middle-class disdain for low superstition, while claiming that Japanese Buddhist thought and praxis carried on where Western philosophy was forced to leave off (having, in the form of Immanuel Kant, talked itself into a corner over the limits of human perception and reason) and about how the best of Western anatomical and psychological knowledge fitted hand in glove with Buddhist insights (Harding 2014b).

Part of the reason why so much cultural and commercial space was available for the likes of Inoue to fill was that Japan's political elite was relatively late to appreciate the importance of mental health legislation and services. Up until the turn of the twentieth century, mentally ill people were still for the most part confined in their homes (often in purpose-built caged rooms) or in secure municipal institutions. Not until a 1919 Mental Hospitals Act, the result of pressure from a German-influenced Japanese psychiatric establishment and Tokyo University's Professor of Psychiatry Kure Shūzo in particular,[4] did 'lunacy' start to be seen as a problem of illness rather than simply of law and order or public safety. Even then, the building and use by the public of new mental hospitals took time. The evidential backing and apparent humanitarian advantages of new forms of care were forced to compete with fear over social stigma and the potentially serious legal implications of some diagnoses,[5] together with a sense that when it came to emotional problems and psychological distress there was relatively little that Japanese psychiatry—rooted as it was in university research and major neuropsychiatric disorders—was inclined to say or do.[6]

The client notes and letters of one of Japan's first psychoanalysts, Heisaku Kosawa, are testament to the sheer range of psychological distress for which the residents of mid-twentieth-century Tokyo failed to find satisfactory care

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[4] On Kure, see Okada (1982); on the relationship between government and psychiatrists in Japan, see Matsumura (2004); Suzuki (2003).

[5] See the discussions in Kitanaka (2011), on the historical relationships in Japan—down to the present day—between government ministries, courts, businesses, and psychiatrists.

[6] A Professor of Psychiatry at Tokyo University admitted as much in 1924. See Kitanaka (2011), p. 35.

in Japan's heavily organic and research-oriented psychiatric mainstream. Enquiries by letter included a woman concerned because her child had become interested in Christianity and was considering the monastic life—she wanted to know whether this might be a mental health problem; a young male correspondent worried by his love of strong women and the fact that he became aroused in exams when the 'five minutes left' announcement was made; and a second young man who had recently met two women on arranged dates (*omiai*) and wanted Kosawa's help to decide which of the two he should pursue (Harding 2014a). Kosawa somewhat mirrored Inoue in his cultural nationalism and his devotion to a modernized form of Buddhism, advocating psychoanalysis as a means by which a person could arrive at a profound and salvific awareness of their weaknesses—with metaphysical as well as psychological and social consequences. Kosawa's relationship with Freud reflected the experience of other Japanese therapists and niche healers of his day: he was disappointed by the narrow view that Freud took of religion (putting it down to Freud's lack of familiarity with non-European religions and family structures), and saw his own psycho-religious theory and practice not as the pragmatic hybrid of two distinct categories that the English term 'psycho-religious' might suggest but rather as a unitary account of human selfhood and its embeddedness in a greater spiritual and moral reality (Harding 2013, 2014a).

As in Japan, so too in India: where governments were interested in mental health but not sufficiently so as to make it a political or financial priority, the natural pluralism of the market and of private philanthropy enjoyed considerable space in which to operate. The public health policy of the British state in late-nineteenth-century India tended to focus on the armed forces, in the wake of serious cholera casualties during recent conflicts. This meant that hygiene provisions and infection control, especially around military barracks, took precedence over other areas of medicine: a strategic choice for a colonial power perpetually short of funds, but also reflective of the low cultural status of mental healthcare in Britain at the time and a reluctance on the part of British personnel in India to pry too deeply into the affairs of Indians, for fear of civil unrest (Harrison 1994). What little existed by way of psychiatric facilities for Indians came under attack in the early twentieth century for poor conditions—dirty, prison-like, and with few staff possessing any psychiatric training. Indians and Europeans continued to be cared for separately right up until Independence in 1947 (Mills 2001).

This left the way open for urban centres like Calcutta to become, no less than Tokyo, hubs of capitalistic quasi-medical entrepreneurship (Mukherjee 2009). Kosawa's counterpart in India was Girindrasekhar Bose: doctor, psychologist, and, like Kosawa, a measured cultural nationalist who challenged the universalizing tendencies of Western mental health discourse—once again personified in Freud, with whom Bose exchanged a number of fairly terse letters (Hartnack 2001).

New Systems and the Globalization of Asian Norms

The Japanese and British Indian political projects of the mid-nineteenth century, which had underpinned far-reaching debates about the mind, culture, and mental health, soured by the late 1940s: British power in India collapsed and Japan's new state drove its people to all-out war and defeat. A fresh, internationalist tone was now set in both countries: Jawaharlal Nehru's India as a forward- and outward-looking secular democracy and Japan-during and after the American occupation (1945–1952)-a beacon of peaceful economic development in Asia.

And yet at least two legacies of the previous era lived on: a relative lack of funding, consensus, and political will when it came to mental healthcare provision, and broad-based cultural nationalisms which, operating alongside various subnational identities from region to religion, continued to inform popular perceptions about the appropriateness or otherwise of mental health practices and goals rooted in Western science and medicine. Yet while there has been ambivalence about the implications for individuals and communities of biomedical psychiatric categories and treatments, especially when tied to neo-liberal ideologies of development, doubts have been raised too about the accuracy and usefulness of essentialist speculation over a purported 'Indian psyche' or 'Japanese psyche'—a combined result of old Western fantasies about the 'East' and the eagerness of some Asian nationalists to play up to these (or create their own) as a means of achieving differentiation and political agency. A final feature of the post-1940s world has been a series of successful Asian cultural contributions to Global Mental Health: yoga and Transcendental Meditation from India; Zen, and Morita and Naikan therapies from Japan.

It had been the repeated claim of Indian nationalists that once the British were gone, India would act fast to undo long decades of underinvestment and inequality—and indeed the Indian National Congress, which succeeded to power in 1947, had been making arrangements for this since the 1930s. In the field of medicine and mental health, remarkable individuals like the psychiatrist J.E. Dhunjibhoy, Superintendent of Ranchi Indian Mental Hospital, had been blazing a trail by trialling the latest treatments developed internationally in his own institution (Ernst 2013). More broadly, useful ground was laid during the last days of colonialism by a Committee headed by an Indian Civil Service Officer named Sir Joseph Bhore, whose illustrious members were commissioned to look into the future of healthcare in India. The Bhore Committee stressed the urgent need to consider public health policy and provision in the context of problems of poverty, unemployment, housing and social welfare, and drastically to upgrade medical education in India. A further impetus came three years later, on the eve of Independence, with a government survey that found there to be no more than 10,000 psychiatric beds for 400 million people: a ratio of one bed per 40,000 people, compared with one for every 300 in England at the time. Most of India's mental health institutions, with the exception of Ranchi and Mysore, were deemed out of date and oriented still towards custody rather than cure or care. Many superintendents and most staff still had no psychiatric training whatsoever, and the Punjab Mental Hospital in Lahore was said to be worse than most Indian jails (Taylor 1946). The report recommended better training, promotion of occupational therapies, separate child psychiatry units, and closer relationships with the community (Krishnamurthy et al. 2000).

And yet the Bhore Committee was largely forgotten after Independence. Indian healthcare developed along a privatized rather than a universal, socialized model, with the psychopharmacology revolution of the 1950s seen as largely obviating the need for small community-based institutions. The 1912 Indian Lunacy Act was not updated until 1987, when a new law provided for, among other things, more progressive definitions and treatment of mental illness (with an emphasis upon treatment rather than custody), new national and state mental health authorities to oversee the work of psychiatric hospitals, and the protection of the human rights of persons with mental illness (PMI) (Narayan and Shikha 2013). A new Act in 2014 updates this with significant fresh provisions, ranging from the decriminalization of suicide to the establishment of a Mental Health Review Commission to review all hospital admissions that go on past 30 days. Patients have the right to appeal doctors' decisions to the Commission; psychosurgery is restricted and electroconvulsive therapy (ECT) without anaesthesia banned; unlicensed establishments are to be clamped down upon; and patients are to be given the opportunity to make an advance directive, indicating preferences for future treatment should they become unable to make such decisions, in addition to the right to nominate a representative for such circumstances.

Although India's national legislative framework has been slow to evolve, and socialized community care remains patchy across the subcontinent, institutions have been established to promote advanced research and the trialling of new forms of mental healthcare. This has been most notably the case with the

All-India Institute of Mental Health (established in 1954), which took as its motto a phrase from the Bhagavad Gita—'Equanimity is the goal of all existence'—and which later became the National Institute for Mental Health and Neurosciences (NIMHANS) based in Bangalore. NIMHANS has contributed towards a series of District and National Mental Health Programmes (NMHP) since the 1980s, aimed at decentralizing and demystifying mental healthcare—in part through specialist psychiatric training given to primary health workers.

Critics have charged, however, that the new NMHP in 2002 moved away from the promotion of service access and community participation in favour of psychotropic medication (with a budget of some US$345 million). Sumeet Jain and Sushrut Jadhav worry that 'the pill ends up standing in for the entire mental health policy', with rural mental health teams in particular lacking the time and training for narrative engagement with patients while patients themselves accept the pill in lieu of understanding or contextualization—and go elsewhere, to folk or faith healers, for these latter things (Jain and Jadhav 2009). In addition, health insurance coverage for mental illness is poor; people suffering from mental illness continue to be referred to in Hindi as *pagal*—'crazy'—and the psychiatric profession is small and generally not well respected (it was recently claimed that there are as many cardiologists in Mumbai alone as there are psychiatrists in the whole of India [Sen 2014]). NGOs have joined the private entrepreneurs, philanthropists, and missionaries of pre- and early post-Independence India in seeking to make up for failures of political will and funding: the Schizophrenia Research Foundation and the T.T. Ranaganathan Research Foundation (substance abuse) operate in Chennai, the Richmond Fellowship Society in Delhi and Bangalore, and the Alzheimer's and Related Disorders Society of India (ARDSI) in Kerala.

A crucial legacy of the late nineteenth and early twentieth centuries is the debate over how mental health relates to culture. Psychotherapy has been a major battleground here, with maverick transcultural psychiatrists such as N.C. Surya deriding a deracinated Indian medical profession [in which he included himself, as someone born in British India who studied extensively in the United Kingdom (Wig 1996)] and calling for forms of therapy that resonate with the aspirations of ordinary Indians. This has led psychiatrists, including Jaswant Singh Neki, R.A. Venkoba, and C. Shamasundar (see above), to seek truly 'Indian' psychotherapeutic paradigms in Indian philosophy and religion (Venkoba and Parvathi 1974; Shamasundar 1979) and in features of family and social life that are seen as marking India out from Western societies. A greater degree of dependence upon family, to an extent that in some Western contexts might be considered grounds for therapeutic intervention (Wig 1996), has been noted as a particular feature of the

Indian context, and a series of Indian psychiatrists have pioneered family-based therapies, which some have claimed as India's distinct contribution to global psychiatry (Murthy 2010; Harding 2011). It could be argued that such therapies possess deep moral importance since they recognize and respect (by drawing inspiration from) the role of families as primary carers for mentally ill people throughout much of India's history. Two further oft-cited examples are a less pronounced focus in India, compared with Western societies, upon individual autonomy (as opposed to a healthy level of dependence) and the relative uselessness of libidinal theories (see Chatterjee et al. forthcoming). In addition, Surya suggested that Hindu teaching prizes a certain degree of 'dissociation' (in opposition to Western integrative goals): 'one is encouraged to be first a non-participant 'witness' of one's own actions, before corrections can occur' (Wig 1996).

One should be extremely wary of talk of an 'Indian psyche' in all of this, and Sudhir Kakar, among others, has pointed to the nonsensical nature of such an idea amidst the diversity of the subcontinent (Kakar 1993). But Indian debates over culture and mental health do reveal three important things about the subcontinent's experience of the globalization of mental health ideas. First, influential members of the Indian psychiatric profession have followed on from the likes of Girindrasekhar Bose in questioning the purported universalism or global nature of psychiatric and psychotherapeutic modalities emerging from Western contexts—and they have done so through a powerful combination of philosophical, epidemiological, and clinical approaches. Secondly, however, there is a danger that the creation and advertising of 'Indian' psychotherapies ends up involving mental health professionals in long-running ideological and political battles over what constitutes mainstream Indian culture. The attention paid to the Bhagavad Gita and the characters of the Ramayana may seem reasonable to non-Indians, but within India, these choices imply an identification of Indianness with Hindu culture that many minority groups, from Muslims to Christians to Dalits (former 'untouchables'), would strenuously contest. Thirdly, there is the further danger of allowing cultural accounts of mental illness and healing to get out of proportion or to distract attention away from much-needed analysis of how social and economic factors contribute towards mental ill health. This last danger is of course latent in both cultural psychology and transcultural psychiatry on the one hand, and in too narrow a policy focus on psychopharmaceuticals on the other.

A second area of controversy in India's postcolonial relationship with the West has been the power exerted by the World Health Organization (WHO). Some have seen the WHO's prominence in Indian policymaking as a form of neocolonialism, but others have noted the influential presence of Indian psychiatrists within the WHO and the generous funding—in the 1970s, at least—that it provided to India. In recent years, the WHO Mental Health Gap Action Programme (mhGAP) and the Movement for Global Mental Health have come in for cautious treatment by experts on low- and middle-income countries (LMICs) contexts, who welcome the involvement of social scientists but ask that the rhetoric of non-specialist and community involvement in providing mental healthcare, which is a part of these programmes, be extended beyond making them 'handmaidens of bio-medical expertise' and instead sources of original and valuable insight. Biomedical intervention may in many contexts be a necessary and helpful first response, but over time the approach needs to become more complex (see Campbell and Burgess 2012).

Mental health in Japan was more successfully restructured in the late 1940s and 1950s than was the case in India. An American turn, under the Occupation, saw an influx of American psychology and Rogerian psychotherapy (Carl Rogers visited Japan in 1960), together with a push—launched through a new Mental Hygiene Law in 1950—for the building of the long-promised network of psychiatric hospitals across the country. Conditions in these hospitals were soon rumoured to be poor, however, with privately run institutions in particular accused of failing to put patients' interests at the heart of their work. Moves towards community care were slowed by an attack on the American ambassador by a disturbed teenager just as a new mental health law was being considered in the mid-1960s, but there has been change nevertheless, thanks in large part to the efforts of a generation of psychiatrists who trained during the heyday of the anti-psychiatry and transcultural psychiatry movements in the 1960s and 1970s (Kitanaka 2011).

Notable contributions to Global Mental Health have emerged from critical thinking in Japan about the particular ideals of 'self' that seem to inform the assumptions of Western mental healthcare—in particular, a rich tradition of writing, dating back to the 1950s, located at the intersection of psychiatry, social psychology, and social and cultural criticism. The doyen of this kind of writing was Takeo Doi, a student of Kosawa who ended up equally critical of his master's Buddhistic maternalism and the emotional frigidity of 1950s American psychoanalysis (Borovoy 2012; Harding 2014a, b). Doi offered his *amae* theory—which refers to a tendency to ingratiate or to presume upon the affection of others, and which rapidly became a staple of both Japanese and Western commentary on a purported Japanese cultural psychology (Borovoy 2012; Dale 1986; Ando 2014)—as a gift to the world: a tendency not unique to Japan, but one that was out in the open there, whereas it was generally repressed to an unhealthy extent in Western cultures.

Amae was just one of a number of self-conscious 'gifts to the world' from Japanese psy professionals from the 1950s onwards, drawn from Japanese religious traditions and from forms of human family and social life allegedly effaced by Western individualism (and/or, depending on your politics, Western-style capitalism) but surviving more or less intact in Japan. To their critics, such claims were no more than spurious attempts to rebuild in the language of 'psy' and mental health the pride and sense of national purpose of which Japan had been robbed by defeat in 1945. And indeed, *nihonjinron*—theories about the Japanese people—have frequently appeared in right-wing discourses that are less than flattering about the West and about other parts of Asia. These theories flourished for a couple of decades after the Japanese economy began to boom in the mid-1960s—the country's apparently miraculous rebirth symbolized by a successful Olympics hosted in Tokyo in 1964 and the advent of the impossibly modern 'shinkansen' bullet trains the same year—and live on now as 'common sense' sociological generalizations in much of Japan's mainstream media. And though writings in this vein have been out of favour in recent years, related ideas have lived on through their embodiment in psychotherapeutic and quasi-psychotherapeutic practices: modern Zen (and specifically the practice of *zazen*, or seated meditation), and Morita and Naikan therapies.

We may deal with Zen relatively briefly, since it is not explicitly a mental health practice in the way that Morita and Naikan are. Suffice it to say that the modern, lay practice of Zen is largely a creation of the newly instrumental view of Japanese religious traditions encouraged by the likes of Enryō Inoue. As Janine Sawada has shown, there had long been a discourse of self-cultivation in Japan, of which the practice of *zazen* was a part, but it was in the late nineteenth and early twentieth centuries that Zen became increasingly the property of lay—that is to say non-monastic—practitioners, who supplied much-needed funds to Buddhist temples in exchange for what was in effect the consultation services of trained monks (Sawada 2014). Although there is much argument about the extent to which the varieties of Zen that are practised globally—and especially in the United States—are 'authentic' continuations of Japanese traditions, there can be little doubt about the influence here upon Global Mental Health discourse of an Asian 'norm': the powerful emotional and psychological benefits—perhaps even the moral or philosophical imperative—of a quiet, disciplined witnessing of one's own mental activity, together with the implied insights about the ultimate sources of internal suffering and the nature of the (no)self (Sharf 1995; Safran 2003).

Morita therapy, pioneered before the Second World War by the psychiatrist Shōma Morita, drew heavily on Zen for inspiration—alongside Morita's highly individual critique of Western psychotherapies (including psychoanalysis, for whose extravagant theories and risible cure rate Morita had only contempt), and his experiences with anxiety. At the core of the therapy is the idea that humans have a natural disposition towards neurosis, and we try to cope with it on the basis of a mistaken dualism that insists one part of the mind is largely able to control the other. Peace lies in relinquishing this mistaken idea, and learning instead to live with reality as it is—as it comes to us (*arugamama*). Morita therapy was self-consciously a product of its period in the 1920s—advertised as a method of healing at once rooted in Japanese culture and yet perfectly in line with scientific theories about the mind (or at least those with which Morita was prepared to agree). It then went on to resonate with a post-war Western generation for whom, although talking therapies were acknowledged to work in many cases, constantly returning to painful ideas could often be counterproductive. Among those in the West to take an interest in Morita therapy was the pioneering psychoanalyst Karen Horney, who travelled to Japan not long before her death in 1952, and the therapy has gone on to be influential in the United States and elsewhere both in its own right and as a reference point for advocates of so-called quiet therapies in general seeking to make their case (Reynolds 1989).

Naikan therapy was mostly developed after the war, as its founder, Ishin Yoshimoto, took steps to secularize an ascetic Buddhist practice known as *mishirabe* (searching oneself) by turning it from a days-long solitary ordeal without food or water to a week's residential therapy in which periods of solitude are interspersed with interviews conducted by 'Naikan guides'. As with Morita therapy, Naikan represents a contribution to Global Mental Health ideas of a practice that is Asian in two senses: drawing from centuries-old Buddhist insights into the workings of the mind, and at the same time identifiably a product of Asian modernization dilemmas from the late nineteenth century onwards (Kondo and Kitanishi 2014).

Conclusion

The Indian and Japanese contexts show the striking breadth of historical forces that play a role in the emergence of modern mental health ideas and practices—from commerce and colonialism to the global circulation of categories and disciplines of knowledge, and from cultural nationalism to the ways in which the inadequate or tardy formulation of government policy opens spaces in which entrepreneurial individuals and interest groups are able to operate. Major contributions to Global Mental Health have resulted, from therapies rooted in revived forms of religious culture—work is ongoing in India into the use of yoga and meditation in depression, schizophrenia, drug and alcohol dependency (Vedamurthachar et al. 2006)—to innovations in family psychiatry (India) and community psychiatry (Japan). National and regional programmes such as India's NMHPs have gone on to be influential in Pakistan, Afghanistan, Bhutan, Nepal, Bangladesh, Iran, Sudan, and Yemen, while in Japan scientific research into dementia and work on patient advocacy and activism look set to become the global contributions of the future (Nakamura 2010).

With—one hopes—the most lurid sociological and psychological essentialisms now in the past (those of both Western and Asian authorship), the way perhaps lies clear for Indian and Japanese professionals and patients to offer to Global Mental Health debates a useful creative tension with, and a considered critique of, the Western paradigms with which they have such a long and rich history of interaction.

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5

Reflecting on the Medicalization of Distress

Gavin Miller

Commentators such as Suman Fernando, Derek Summerfield and Ethan Watters have drawn attention to the troubling interaction of the Movement for Global Mental Health with local, non-Western cultures of distress, illness and healing. Their suspicions go hand in hand with their contextualization of hegemonic Western medical models within the wider discourse and practice of postdevelopmentalism. Postdevelopmental thinking criticizes the presumption that the Western model of development can simply be replicated across the globe, irrespective of the cultural, societal and geographical contexts. This chapter explores recent postdevelopmental critique of the dominant ideology within the Movement for Global Mental Health by locating what may seem to be primarily clinical debates within wider arguments about the validity of development theory. If we accept the postdevelopmental unmasking of the medicalization of distress, then what remains in terms of a positive model for the interaction between Western and non-Western cultures of distress, illness and healing?

In his popularizing book *Crazy Like Us*, the journalist Ethan Watters eloquently summarizes and synthesizes an international range of research that expresses concern about the medicalization of distress promoted by the Movement for Global Mental Health. He offers a persuasive overview in which globalizing North American expertise threatens to homogenize local forms of distress by imposing upon them an unwarranted psychiatric model.

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Watters states that “[o]ver the past thirty years, Americans have been industriously exporting their ideas about mental illness”, but warns that “[i]n teaching the rest of the world to think, they have been, for better and worse, homogenizing the way the world goes mad” (Watters 2011, p. 2). Watters discusses a variety of psychiatric diagnoses—including anorexia, schizophrenia, post-traumatic stress disorder (PTSD), and depression—that he regards as imposed upon local forms. He draws, for instance, upon dialogue with Laurence Kirmayer to argue that the biomedical account of “depression” may obscure and mystify the local psychosocial meaning of distress: “feelings and symptoms that an American doctor might categorize as depression are often viewed in other cultures as something of a ‘moral compass’, prompting both the individual and the group to search for the source of the social, spiritual or moral discord” (Watters 2011, p. 214). In making this claim, Watters echoes Kirmayer’s published views on the exportation of “depression” from North America to Japan, where the latter perceives an “aggressive medicalization” (Kirmayer 2002, p. 316). While conceding that “crippling depression should be recognized and treated effectively”, Kirmayer expresses concern about the extinction of “forms of dissatisfaction and distress that may be sensitive indicators that something is wrong not with the individual’s psyche but with the social world” (Kirmayer 2002, p. 316). Indeed, to Kirmayer, such extinctions betoken the spread of a neo-liberal “global monoculture of happiness” based on values of pleasure, self-fulfilment and (perhaps ultimately) consumerism (Kirmayer 2002, p. 316). The ecological metaphor of “monoculture” is echoed and amplified by Watters, who warns that “[w]e should worry about this loss of diversity in the world’s differing conceptions and treatments of mental illness in exactly the same way we worry about the loss of biological diversity in nature” (Watters 2011, p. 8).

Suman Fernando has expressed related concerns about the Movement for Global Mental Health, which, he argues, “promotes westernization (as ‘globalization’) and the ideology that there are ‘global’ remedies for mental ill health available in ‘evidence based’ medicine of western psychiatry” (Fernando 2014, p. 128). Fernando offers two criticisms of the World Health Organization’s (WHO) “promotion of a bio-medical diagnosis-based approach to mental health development” (Fernando 2014, p. 128). Firstly, “medicalization of ordinary (understandable) anxieties and depressions” (Fernando 2014, p. 128) may distract from problems that are social, political and economic. Medicalization is thus an imposition of Western individualism, a false consciousness that mystifies social reality. Secondly, “by promoting the use of drugs as remedies for personal problems conceptualized as ‘illnesses’, the medicalization process […] is undermining indigenous, culturally acceptable means of help and support for people with personal or social problems resulting in distress" (Fernando 2014, p. 128). Medicalization is thus also a way of eroding local resources and enforcing dependency upon the West in low- and midde-income countries (LMICs).

Changing Models

As the preceding vocabulary of local forms of "distress" indicates, such criticisms of the Movement for Global Mental Health have emerged in conjunction with models of culturally dependent psychopathology more sophisticated than those previously used. These more dynamic accounts address problems in what may seem, paradoxically, to be the central object of any anthropological inquiry, namely, "culture". As Adam Kuper explains, the term "culture" invites belittlement of the society under investigation: "culture" is a "hyper-referential word" that is used instead of more precise, and more affirmative terms, such as "knowledge, or belief, or art, or technology, or tradition, or […] ideology" (Kuper 1999, p. x)—or, one might add, "medicine". The assimilation of manifold activities to mere "culture" may mean that "culture shifts from something to be described, interpreted, even perhaps explained, and is treated instead as a source of explanation in itself" (Kuper 1999, pp. x–xi).

The analytic insufficiency of the term "culture" motivates newer discourses of mental health and illness in LMICs. The concept of "idiom of distress" in its original usage by Mark Nichter (Nichter 1981) moves beyond a simplistic medical model of cultural dependence in mental illness. Nichter recalls his uneasiness about "the rather static way in which culture and indigenous medical traditions were being represented in ethnomedical studies", alongside a related concern that "anthropologists and transcultural psychiatrists were paying far too much attention to the 'whatness' of particular cultural modes of expressing distress (possession states, witchcraft, 'cultural bound syndromes' and so on) and too little attention to 'Why this?' questions" (Nichter 2010, p. 403). Nichter's concept of "idiom of distress" challenges a reified, externalized view of culture in which culturally dependent psychopathology results either from culture shaping an underlying disease process present in an individual ("cultural pathoplasticity") or from culture directly causing an exotic culturally bound syndrome within an individual in a manner akin to that of a biological pathogen ("cultural pathogenesis"). The latter model, for instance, is apparent in the post-war account of the East Asian penis-shrinking disorder *koro* as a culture-bound syndrome. For P.M. Yap, writing in the 1960s, the genesis of koro, with its distinctive "conviction of penis shrinkage" (Yap 1965, p. 43), lies in culturally specific "traditional ideas of sex physiology (or pathology)" (Yap 1965, p. 47). Without "the factor of cultural expectation" derived from folk physiology (Yap 1965, p. 47), individuals who masturbate or undergo nocturnal emission would not expect to experience shrinking of the penis (consequent, in the sufferer's view, upon an imbalance of the masculine *yang humour* due to semen loss). In Yap's account of the aetiology of *koro*, there is little sense of the agency of his patient sample, who are depicted as a ragbag assortment of losers, most of whom are "of immature personality, lacking confidence in their sexual capacity, and in a broader sense, their virility" (Yap 1965, p. 45). They are, in other words, natives whose psychological deficiencies make them exceptionally susceptible to the hocus-pocus, as Yap would see it, of traditional Chinese medicine (TCM).

The idioms of distress approach, which has recently been ratified by DSM-5 under the rubric "Cultural concepts of distress" (APA 2013, p. 758), seeks to avoid this crude epidemiology in which a cultural pathogen (e.g. belief in TCM) infects the psychological equivalent of a weakened constitution. When Nichter stipulates that "[i]dioms of distress are socially and culturally resonant means of experiencing and expressing distress in local worlds", he intends to give due weight to the causal significance of "present stressors", while also recognizing that such idioms are, for the afflicted individual, a way of actively communicating and conceiving their distress (Nichter 2010, p. 405). While they might be "indicative of psychopathological states", these idioms function also as "culturally and interpersonally effective ways of expressing and coping with distress" (Nichter 2010, p. 405). The movement towards an idioms of distress approach was by no means solely due to Nichter's intervention: there are precursors even in the 1950s, such as Grace Harris's account of the ritualized "idiom" of *saka*, a possession-like state found in the Taita community of Kenya (Harris 1957, p. 1065). Nonetheless, Nichter's conceptual statement consolidated the movement towards understanding the cultural meaning and societal functioning of local, illness-like disorders. The application of an idioms approach is readily apparent in, for instance, Maria A. Oquendo's account of the Hispanic idiom of distress, *ataque de nervios*. Whereas Yap dwells on the alleged stupidity and ignorance of his patients, Oquendo stresses that *ataque de nervios* is a "culturally condoned expression of distress communicated by a person who feels overwhelmed by an event or situation" (Oquendo 1995, p. 64). The greater prevalence of the condition among women invites the hypothesis that the idiom is "a permissible way for women to express rage" in a cultural context of *Marianismo*, whereby "[w]omen are expected to accept misfortune stoically and silently" (Oquendo

1995, p. 63). In any case, whatever the gender of the sufferer, the clinical response should be primarily oriented, in Oquendo's view, towards removing the stressor, and to support from the community, including family, church, and popular remedies (Oquendo 1995, p. 64).

Historical Consciousness

Such changes in the expert discourses of cultural psychiatry correlate with an increasingly self-critical historical understanding of colonial and postcolonial psychiatry, through which clinical professionals have become aware that psychiatric diagnostic and explanatory systems are only semi-autonomous of wider political agendas. It is partly because of critical historiography that theories of indigenous inferiority and exoticism have gradually ceded to more sophisticated, dynamic and affirmative models of non-Western cultural resources. A brief survey of contemporary history of colonial and postcolonial psychiatry reveals the political analyses with which the clinical professions are confronted.

In his study of colonial-era ethnopsychiatry in Africa, Jock McCulloch argues that "European colonialism […] provided the social setting for ethnopsychiatry and it is impossible to separate the story of the profession from the colonial enterprise" (McCulloch 1995, p. 1). The ethnopsychiatric project, which lasted from around 1900 to 1960 (McCulloch 1995, pp. 1–2), was an effort to "describe the study of the psychology and behaviour of African peoples" (McCulloch 1995, p. 1). It was epitomized, for McCulloch, by authorities such as the English-born J.C. Carothers (1903–1989), a Kenyan ethnopsychiatrist and author of the WHO-commissioned *The African Mind in Health and Disease* (Carothers, 1953). As McCulloch convincingly demonstrates, this text was little more than a UN-sponsored "theory of African inferiority" (McCulloch 1995, p. 63) that legitimated the interests of African colonizers: Carothers "expanded his explanation of the Africans' deficiency to include culture, race, brain morphology, morality and intellectual endowment. […] The African Mind was not a study of mental health but a politics of possibilities—a theory of citizenship, economic behaviour and moral failing" (McCulloch 1995, p. 61).

An African response to the brazenly colonial ideology of ethnopsychiatry was developed by the celebrated Yoruban psychiatrist Thomas Adeoye Lambo (1923–2004), whose work in Nigeria came to prominence in the 1950s, just as the authority of McCulloch's ethnopsychiatry was beginning to be eroded by decolonization. Lambo is perhaps best remembered for the challenge to Western expertise in the success of his Aro village system, whereby schizophrenics were given care in the local community, rather than in a hospital setting. As Matthew M. Heaton explains, "Lambo credited the cultural emphasis on community care in African healing systems, and his own reformulation of it at Aro Village, as the most apparent contribution to the recovery and reintegration of African schizophrenics into their societies" (Heaton 2013, p. 112). Such experiments, though, should not be misinterpreted as a defence of culturally specific therapeutics—the Aro model was conceived as potentially universalizable. In the work of Lambo and others, belief in universals of progress was intimately linked with belief in universals of psychopathology: "Nigerian psychiatrists' political and professional agenda meshed in ways that led them to repudiate racist conceptions of the inferiority of African psyches […] and to replace them with a theory of the universal similarities of human psychological processes that transcended perceived boundaries between races and cultures" (Heaton 2013, pp. 4–5). Tolani Asuni, for instance, proposed that the apparently low rate of depression in Nigeria (as indicated by low suicide rates) was only because "depressive illness in this country does not manifest itself by feelings of guilt, unworthiness, and self-reproach" (Asuni 1962, p. 1096). Nigerian cultural factors, in Asuni's view, moulded the underlying (putatively universal) psychopathology in a way that made familiar indices unreliable. In the context of such work, Lambo thus "began to produce research arguing for the basic universal similarity of human psychology, irrespective of race, religion, ethnicity, or geography" (Heaton 2013, p. 52)—a thesis that would later be fundamental to the Movement for Global Mental Health.

Historiography shows that while Carrother's ethnopsychiatry was an unconscious medical legitimation of colonial paternalism, Lambo's psychiatry was more self-consciously an expression of the modernizing ambitions of postcolonial Nigeria. Nor were such universalistic programmes of research confined to Africa: as Sumeet Jain and Sushrut Jadhav explain, postcolonial India saw "attempts to develop an 'Indian psychology and psychiatry' by uncovering mental health concepts within indigenous texts and traditions" (Jain and Jadhav 2008, p. 567). The aim was not an autonomous ethnopsychiatry but rather a developmentalist validation of "indigenous Hindu traditions" via a "linking of 'modern' psychiatry to 'traditional' Indian knowledge systems" (Jain and Jadhav 2008, p. 567). However, as faith in postcolonial development along Western lines has waned, so there has emerged an increasingly historically self-aware strand of psychological and psychiatric thought and practice. As Richard Peet and

Elaine Hartwick explain, the postcolonial era was one in which "the economies of Third World societies had already been captured, in structure and orientation, by the capitalist world market" (Peet and Hartwick 2009, p. 165), so that formal independence really ushered in an era of "neocolonialism" or "neo-imperialism" in which direct "hard" power was replaced by indirect social, political and cultural hegemony. Peet and Hartwick argue that the USA has emerged as the dominant neo-imperialist after the collapse of the Soviet Union: "Contemporary U.S. neoimperialism has the confidence to control others in the long term by setting ideals that people strive for rather than controlling bodies through violent intimidation" (Peet and Hartwick 2009, pp. 165–166).

The social psychologist Ignacio Martín-Baró (1942–1989), who was active in El Salvador until his assassination during the civil war (Portillo 2012, pp. 77–82), proposed a "liberation psychology" for the neocolonial age. He criticized dominant psychologies "imported from the United States" (Martín-Baró 1996, p. 20) for their "positivism, individualism, hedonism, […] homeostatic vision, and ahistoricism" (Martín-Baró 1996, p. 21). Such psychologies were an ideology and instrument which "served […] to strengthen the oppressive structures, by drawing attention away from them and toward individual and subjective factors" (Martín-Baró 1996, p. 19). He trenchantly criticized the intellectual vices of a positivist discipline that, "[r]ecognizing nothing beyond the given, […] ignores everything prohibited by the existing reality" (Martín-Baró 1996, p. 21): a "positivist analysis of the Salvadoran campesino would lead one to the conclusion that this is a machista and fatalistic person", just as "the study of the intelligence of blacks in the United States leads to the conclusion that the IQ of blacks is on average a standard deviation below that of whites" (Martín-Baró 1996, p. 21). The supposed fatalism of the Salvadoran people was for Martín-Baró exemplary of a positivist conclusion—this contingent reality was due to a lack of social and political autonomy which forced the Salvadorans "to learn submission and expect nothing from life" (Martín-Baró 1996, p. 27).

The preceding brief survey indicates that the expert discourses of mental health in non-Western settings have been strongly inflected by contemporaneous ideologies and institutions. Carother's theory of the African mind was an apology for colonialism; Lambo's work in Nigeria responded to racism within a context of modernization and development; Martín-Baró's liberation psychology was a consciously politicized resistance to US neocolonialism in Central America. What then underpins contemporary professional anxieties regarding the global medicalization of distress? What are the political meanings of a more affirmative response to non-Western cultures of mental health?

Postdevelopmentalism

As the example of Martín-Baró suggests, contemporary suspicion of the Movement for Global Mental Health can be fruitfully contextualized by reference to postdevelopmentalism, and its opposition to ideologies of universal, stage-by-stage progress on the Western model. Arturo Escobar, a prominent theorist within the movement, argues that

> [d]evelopment […] has to be seen as an invention and strategy produced by the "First World" about the "underdevelopment" of the "Third World" […]. Development has been the primary mechanism through which these parts of the world have been produced and have produced themselves, thus marginalizing or precluding other ways of seeing and doing. (Escobar 1992, p. 22)

Escobar identifies the post-war period of decolonization as precisely the time when a new apparatus of global power emerges. In 1949, US President Harry Truman makes "his appeal to the United States and the world to solve the problems of the 'underdeveloped' areas of the globe" (Escobar 1995, p. 3), thereby beginning an enormous enterprise that aimed to replicate globally "the features that characterized the 'advanced' society of the time—high levels of industrialization and urbanization, technicalization of agriculture, rapid growth of material production and living standards, and the widespread adoption of modern education and cultural values" (Escobar 1995, p. 4). The consequent discursive construction of LMICs as "underdeveloped" is significant in the present discussion, for, as Escobar explains, clinical and therapeutic discourse was central to the identification and treatment of supposed pathologies: "Development proceeded by creating abnormalities ('the poor', 'the malnourished', 'the illiterate', 'pregnant women', 'the landless') which it would then treat or reform" (Escobar 1992, p. 25).

In the wake of critics such as Escobar, there arose a counterdiscourse of "postdevelopmentalism", affiliating scholars who "shared a critical stance toward established science; an interest in local autonomy, culture and knowledge; and a position defending localized, pluralistic grassroots movements" (Peet and Hartwick 2009, pp. 226–227). Fernando's suspicion of the Movement for Global Mental Health is clearly in the spirit of postdevelopmentalism: he criticizes “the promotion of a bio-medical diagnosis-based approach to mental health development in LMICs”, with its corresponding insensitivity to “the notion of mental health as a variable concept across cultures, covering a wide range of problems largely of a social and psychological nature” (Fernando 2014, p. 128). A still more trenchant critique is provided by Derek Summerfield, who argues that development in the field of mental health is little more than neocolonialism:

> Psychiatric universalism risks being imperialistic, reminding us of the colonial era when it was pressed upon indigenous people that there were different kinds of knowledge and that theirs was second rate. Socio-cultural and socio-political phenomena were framed in European terms and the responsible pursuit of traditional values regarded as evidence of backwardness. (Summerfield 2012, p. 525)

Summerfield accordingly calls for recognition that there are “many ethnopsychiatries in the world” and praises the local African healer whose “treatments are meant to extend only to a specific local population well-known to him, and of which he is culturally a part” (Summerfield 2012, p. 527).

Such defences of local, “sub-altern” knowledge underpin the affirmation of local “idioms of distress” against medicalization. They proceed from post-developmental suspicion of discourses which presuppose “[a] linear view of history in which the West is further along a given path of progress than Third World countries” (Peet and Hartwick 2009, p. 211). The postdevelopmental critique of the Movement for Global Mental Health does, however, face a dilemma. While one might well lament the coercive erosion of local ethnopsychiatries by globalized Western expertise, the alternative of a cultural quarantine seems equally unattractive (and, indeed, simply unrealistic). Such an ambition is, however, apparent in Watters's reliance upon the rhetoric of biodiversity, manifest in his claim that “[w]e should worry about this loss of diversity in the world's differing conceptions and treatments of mental illness in exactly the same way we worry about the loss of biological diversity in nature” (Watters 2011, p. 8). Although Watters is a popularizer, his rhetorical clarity helpfully articulates positions held by academic researchers. In an echo of Summerfield's contention that Western biomedical psychiatry is merely “one of many ethnopsychiatries in the world”, David Ingleby warns that “[g]rassroots initiatives and indigenous approaches receive little attention, and are threatened with extinction by the large-scale importation of biomedical approaches” (Ingleby 2014, p. 335).

As Esa Väliverronen remarks, “biodiversity” is much more than a “normal scientific concept”; it is, instead, “about almost anything that is good and under a threat in our natural environment” (Väliverronen 1998, p. 31). Indeed, the concept is so normatively weighted that its aura can even seemingly transfer from biological phenomena to those that are explicitly cultural: biomedical psychiatry is an invasive flora that homogenizes the cultural landscape, overwhelming indigenous “grass-roots”. This non sequitur hints, in my view, at the weakness of the case that cultural “convergence” or “synchronization” in culturally dependent psychopathology (and therapeutics) should be regarded as loss (or “extinction”, in bio-rhetoric). As I have argued elsewhere (Miller 2014), it is hard to endorse this view without assuming some kind of cultural essentialism, of the kind previously provided by racial and ethnic psychology. Consider the case of a hypothetical South American whose idioms of distress migrate from nervios to depression:

> If Consuelo from South America reads English-language pop psychology, and stops having *ataques de nervios* and starts having depression, then her depression is as much her idiom of distress as nervios used to be. If this change is to count as a loss of Consuelo’s culture, then we need some sense of what Consuelo’s idioms of distress should be—her “real” or “authentic” culture, as opposed to the one she actually has. (Miller 2014, p. 132)

Of course, Consuelo’s change could be a loss under different models (e.g. perhaps *nervios* is less harmful or stigmatizing than depression), but this is distinct from the idea that what is lost is Consuelo’s culture.

Moreover, even if we think of Consuelo’s change not as a loss for her (or her community), but as a loss of global variegation, there remains the problem that concern with cultural diversity can be seen equally as a demand emanating from high-income countries (HICs), one in which “[t]he Western expert speaks on behalf of the putatively threatened ‘other’, demanding ‘preservation’ much as the earlier imperialists demanded ‘education’ and ‘enlightenment’” (Miller 2014). But to demand preservation is to turn a blind eye to the potential for exploitation and mystification within local cultures of illness and health: cannot ethnopsychiatry itself be an ideological mechanism within non-Western social systems? Must we accept that “Oppositional Defiant Disorder is a daft, downright harmful myth promulgated by the American Psychiatric Association”, but suppose only that phenomena such as *nervios* and *koro* are “imperilled resource[s] for expressing distress within local systems of meaning” (Miller 2014)? Consider again

Oquendo's sympathetic account, where she calls for "recognition of *ataque de nervios*" in the "mental health care of Hispanic women" (Oquendo 1995, p. 64). The feminist points that Hispanic women might care to challenge the culture of *Marianismo*, and to openly express their anger, rather than to rely upon nervios, seems entirely absent from Oquendo's analysis.

Beyond Preservationism

If cultural preservationism is both unworkable and undesirable, then some sense of a "healthy" encounter is required. This is why Fernando attempts to distinguish between two forms of social and cultural contact. He calls the undesirable variety "forced globalization", and regards it as an expression of "neo imperialism" (Fernando 2014, p. 14). This phenomenon "may take the form of western systems (of psychiatric diagnosis, for example) being imposed as a condition of economic aid for supposed modernization of health systems; or more subtly through pressures from evaluation of institutional systems or advice of experts from (western) centres of excellence" (Fernando 2014, p. 14). However, as Fernando quite plausibly argues, a less coercive "passive globalization" (Fernando 2014, p. 14) may be distinguished. This occurs simply because "cultural exchanges and cultural diffusion across the world are inevitable", and "groups of people in communication with each other share ideas, technologies, and so on" (Fernando 2014, p. 14). Admittedly, the analytic framework in Fernando's distinction is somewhat lacking: the more benign form of cultural "hybridization" is neither "passive" nor "a natural process" (Fernando 2014, p. 14). There needs to be some fuller account of the criteria for a benign cultural encounter (though we might guess at some of the ideal elements—reciprocity, equality, non-coercion, etc.). However, the phenomenon seems real enough: researchers such as Kitanaka have shown that the medicalization of distress—in HICs at least—need not be entirely a mystifying, top-down imposition. In her work on the medicalization of depression in Japan, she perceives a more equivocal "ground-up medicalization in the age of globalization, when both local psychiatrists and their patients increasingly use psychiatric language to mediate the immense tensions involved in global-formation and strive to find avenues for asserting local agency" (Kitanaka 2012, p. 197).

Kitanaka's analysis, which identifies something close to Fernando's "passive globalization", applies of course to a high-income nation-state very different from the LMICs that are faced with the WHO's demand to "scale up" services. It may then prove instructive to conclude with a series of provocations in which non-Western "ethnopsychiatries" have challenged Western psychological expertise—indeed, have challenged the very terms of debate regarding "medicalization of distress". As various researchers have argued, the phrase "idiom of distress" may be understood from a non-Western perspective as a Western imposition—as a mode of power that aims to (re)produce psychologized Western subjectivity. Sharon Alane Abramowitz makes this argument in detail with reference to the Liberian popular illness, *open mole*, which is distinguished by the perception of a "soft spot on top of the skull," and is "commonly associated with many symptoms, including: severe headache, neck pain, back pain, fatigue, weakness, nightmares, troubled sleep, loss of appetite and social withdrawal" (Abramowitz 2010, p. 356). Drawing upon her own fieldwork in Liberia, Abramowitz explains how *open mole* came to be understood within Western-informed interventions as a condition that was primarily a symbol for something else. Complaints of *open mole* were interpreted as signs of another kind of suffering, namely psychological "distress": "The first move in translating the idiom of *open mole* into humanitarian practice was to isolate *open mole* as a culturally specific idiom of distress that was also an empty signifier"; local communities were thus taught that "*open mole* was a displacement of something else; that it was a misapprehension of the true cause of suffering" (Abramowitz 2010, p. 364). It could then be paired up with various established Western biomedical diagnoses, such as psychosis, PTSD, and depression (Abramowitz 2010, p. 369).

The assumption was that because *open mole* lacked a clear biomedical pathogenesis, its proximate cause was therefore psychological distress which, given the Liberian cultural context, was transformed (somatized) into bodily symptoms. The concept of distress therefore functioned as a hidden causal category mediating between Western and non-Western nosology; yet, as Abramowitz shows, the presence of such psychological "distress" was notional and entirely absent from the indigenous understanding of *open mole*. A similar point is made by Heaton in his discussion of Roger O.A. Makanjuola's work on *ọdẹ orí*, a Yoruban disease "characterized by a set of core symptoms, notably 'a sensation of an organism crawling through the head and sometimes also other parts of the body, noises in the ears and palpitations', often accompanied by a variety of other somatic complaints" (Heaton 2013, p. 186). In Heaton's reading of Makanjuola, Westernized medicine mistakenly prioritizes "the psychological above the somatic symptoms in the diagnostic process", regarding the bodily sensations as somatized expressions of psychological suffering "such as anxiety or depression" (Heaton 2013, p. 187). As Makanjuola himself proposes, "It is just as feasible, though perhaps less acceptable to the Western trained psychiatrist that the depressive and anxiety symptoms found in these patients are secondary to an underlying disorder—‘*ọdẹ orí*’!” (Makanjuola 1987, p. 234).

The gist of such arguments is neatly captured by Malcolm MacLachlan, who identifies the parochialism in the Western ethnopsychiatric tendency to “misinterpret the meaning of somatic complaints as the ‘masked’ presence of cognitive distortions, low self-esteem, and low mood, etc” (MacLachlan 2006, p. 101). This is not, of course, to deny that *open mole* or similar syndromes are culturally dependent. But what is in question is the premise that a psychological cause such as “distress” must be proximate, with cultural factors merely standing conditions that enable a particular somatizing idiom, or “somatization disorder” (MacLachlan 2006, p. 98). This problematic assumption is part of a larger mismatch between Western and non-Western systems of medicine. Since (presumably) no biomedical pathogen can be identified for *open mole*, *ọdẹ orí*, and their kin, Western medicine has handed the condition over to psychological medicine: the condition is “in the mind”, not the body. Yet, from the experiential perspective of the sufferer, the disease is in the body, not the mind. The encounter thus shows up Western medicine’s difficulty in dealing with an illness that is (1) culturally dependent, lacking biomedical pathogenesis; (2) ontologically subjective (experienced as symptoms, not presented as signs); and (3) primarily somatic in its experiential tenor, rather than affective, cognitive, or conative. The postulation of “distress”, as Abramowitz clearly shows, is a way of modulating such conditions into the realms of affect and adapting them to Western preconceptions. As MacLachlan remarks:

> In the west, people are so versed in the notion of psychosomatic problems (where the psychic is primary and the soma secondary) that even explaining the somatopsychic (where the soma is primary and the psychic secondary) is hard going. As a psychologist, even writing the very word “somatopsychic” makes me feel awkward. (MacLachlan 2006, p. 100)

What is missing from expert Western discourse, as MacLachlan indicates, is a positive way of representing and thinking about the phenomenology of body illness in the absence of biomedical pathogenesis. Yet the advantages of being able to do so would seem obvious: what would it mean to understand not only open mole but also similar Western conditions as real, but neither biomedical nor psychosomatic? According to Alix Rolfe, MU(P)S, medically unexplained (physical) symptoms—typified by conditions such as irritable bowel syndrome, chronic fatigue syndrome, and fibromyalgia—cost the UK’s National Health Service over £3 billion per year (Rolfe 2011, p. 250). There seems clear potential here for the “rest” to speak back to the “West” with respect to the latter’s understanding of MU(P)S, and to offer alternatives to the stark dichotomy between physiological and psychosomatic explanation. As Laurence Kirmayer argues, the challenge is to develop accounts of MU(P)S that avoid “a narrow biomedical framework that seeks only to identify and correct physiological perturbations”, while also eschewing “psychological explanations that emphasize the inner theatre of the mind” (Kirmayer et al. 2004, p. 670).

Conclusion

Postdevelopmental theory has underpinned an intellectually sophisticated and culturally respectful critique of the dominant, biomedical model within the Movement for Global Mental Health. Pre-empting calls within the West for a movement beyond naive biomedical paradigms of mental health (Bracken et al. 2012), commentators such as Nichter, Watters, Fernando and Summerfield have offered an historically, politically and anthropologically informed defence of local idioms of distress, and corresponding systems of healing. Admittedly, widespread acceptance of their arguments within the Movement for Global Mental Health has yet to be secured, and only time will tell how much of an impact their contribution has upon the assemblages of global mental health. But for those who are sympathetic to their critical position, there are important issues to explore further, even while accepting a healthy scepticism towards the neocolonial medicalization of distress in LMICs. As I have argued, there is a risk (apparent, for instance, in the rhetoric of Watters, Summerfield, and Ingleby) that a false opposition may be promulgated, in which the only alternative to psychiatric neocolonialism is a cultural preservationist defence of local systems of distress and healing—as if the latter were endangered flora and fauna, rather than complex social, cultural and psychological phenomena that may themselves legitimate and accommodate injustice. Fernando’s reminder that cultural diffusion, encounter and change can also be benign is therefore apposite. What remains to be articulated is a positive model of the encounter between various forms of Western expertise, including but not limited to biomedicine, and the equally variegated ethnopsychiatries and popular systems distributed across the globe. The challenge to the concept of somatization has been offered in this discussion as a good example of a genuinely informative encounter, one in which non-Western systems have been able speak back to, and unsettle, Western systems of medical classification and explanation. By picking out, and reflecting upon, this and other such positive encounters, it may be possible to articulate a stronger normative model of psychiatric hybridity in the global age.

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6

Diverse Approaches to Recovery from Severe Mental Illness

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Severe mental illness (SMI) is an umbrella term referring to schizophrenia spectrum disorders, schizoaffective disorder, bipolar disorder and major depressive disorder. These disorders are associated with significant social and functional impairment and exert a huge toll on health and wellbeing across the world (Corrigan et al. 2008). Indeed, it is estimated that neuropsychiatric conditions (includes SMIs) constitute 13% of the global burden of disease (WHO 2008), and schizophrenia is the fifth leading cause of years lost to disability for men and the sixth leading cause for women worldwide (WHO 2008). Likewise, the global economic burdens associated with neuropsychiatric conditions exceed those associated with all other major categories of non-communicable disease (Bloom et al. 2011). There is recognition that investing in the prevention and treatment of SMIs is a global public health imperative (Whiteford et al. 2013).

In recent years, the redefined and renewed notion of "recovery" has been enthusiastically embraced by mental health service users, clinicians, researchers and governments across the English-speaking world. Probably the most

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widely utilized definition of this redefined recovery is from Anthony's seminal paper, where he writes that:

> Recovery is a deeply personal, unique process of changing one's attitude, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness. (Anthony 1993, p. 15)

Because recovery can often mean different things to different people and can be used differently depending on the contexts (e.g., Pilgrim and McCranie 2013; Jacobsen 2004), some researchers have highlighted the difficulty inherent in agreeing upon a clear or standard definition for recovery, such as the one presented by Anthony above. Potential problems might be related to the willingness of service providers to truly implement recovery (as opposed to just paying lip service to the concept), determining who gets to define "recovery" (service users or professionals), and whether service provision can keep pace with the ideals of recovery. Moreover, researchers have found that sometimes efforts, guided by North American ideals to "empower" people with schizophrenia to become esteemed self-made citizens, can generate more stressful sociocultural conditions for people whose daily lives were already marked by stress (Myers 2010). These and related issues may have implications for the design and implementation of recovery-oriented services, especially in new contexts. Indeed, a renewed notion of recovery has not yet reached most low- and middle-income countries (LMICs), which continue to struggle to provide the most basic mental health care, let alone the type of recovery-oriented services delivered by a panoply of professionals including social workers, case managers, clinical psychologists, nutritionists, vocational rehabilitation or occupational therapists.

Due to inadequate resources, poor infrastructure and lack of political will, the implementation of renewed models (such as recovery) has not yet been a pressing priority in LMICs (Adeponle et al. 2012). Staying afloat, rather than moving forward, is a difficult enough endeavour for mental health services in LMICs, and explicit discourse about "recovery" has been notably absent from these countries. However, as will be revealed in this chapter, absence of official discourse on recovery does not necessarily mean that nothing can be learned about recovery in LMICs. The concept of recovery has not yet emerged as an organizing framework in the Global Mental Health (GMH) agenda, despite the fact that governments, organizations and funding agencies are calling for increased action on the ground in developing countries. As such, a discussion of recovery in different contexts, along with an identification of key connecting threads across these various contexts, might be particularly relevant. This will ensure that any explicit attempt to implement recovery-oriented practice in developing counties is conducted in light of these diverse notions of recovery.

In this chapter, we thus present three carefully chosen case studies from three different countries in order to compare and contrast how recovery is conceptualized, discussed and implemented. These case studies are drawn from (1) the USA, (2) New Zealand and (3) Nigeria. The USA was chosen because "benchmark" recovery definitions, models and interventions have their provenance within that country. New Zealand was chosen because ideas of recovery dominant within that country uniquely emphasize cultural and communitarian aspects of recovery. Nigeria was chosen because it illustrates how the notion of recovery is simultaneously present and absent in many LMICs.

The United States

The development of the recovery model can be traced to various parallel activities in the USA during the 1990s. Firstly, a number of consumer/survivors with SMI wrote poignant and well-read personal memoirs detailing the lived experience of recovery (and barriers and facilitators thereof) from a first-person perspective (Mead and Copeland 2000). These memoirs appeared emblematic of the wider experience of people with SMI (Ridgway 2001). Perhaps most significant among these are the various writings of Patricia Deegan, which have played a major role in furthering understanding about the concept of recovery. Deegan notes that "recovery is not the same thing as being cured" (1997, p. 20) and instead involves being "in the driver's seat of my life, I don't let my illness run me" (1993, p. 10). A common theme running through these first-person perspectives is a desire to live an independent and autonomous life in the community, even in the presence of ongoing symptoms. Davidson and Roe (2007) call this "recovery in mental illness".

Secondly, research stemming from rehabilitation science suggested that new interventions and supports can effectively facilitate this desire for independence and autonomy. For example, the development and refinement of supported employment interventions suggested that people with SMI, who had previously been written off as unemployable, could find gainful employment in the community (Mueser et al. 1997; Drake et al. 1996). Likewise, new models of supported housing indicated that people with SMI need not live in heavily monitored congregate housing settings, but instead could live independently without restrictive rules or on-site supports (Carling 1993; Tsemberis 1999). Common across these new interventions was a desire to facilitate autonomy among people with SMI, moving them away from a service-dependent lifestyle towards a normative life in the community.

Thirdly, a series of epidemiological studies indicated that as many as 40% of people with SMI show complete remission of symptoms 5–10 years after first onset (Harding and Zahniser 1994; Hegarty et al. 1994; Harding et al. 1987). These studies indicated that, contrary to popular belief, SMI is not by definition a chronic and deteriorating condition. Rather, clinical recovery as traditionally defined, is a common outcome for people living with SMI, with Davidson and Roe (2007) calling this "recovery from mental illness".

Taken together, the above led to a formulation and understanding of recovery in the USA as living an autonomous and meaningful life in the community, rather than being an object of an overbearing and paternalistic mental health system. This is perhaps best encapsulated in the now seminal definition of recovery quoted at the beginning of this chapter, developed by Dr William Anthony from the Boston University Center for Psychiatric Rehabilitation (1993).

The concept of recovery has been officially endorsed in the USA through various governmental activities. Probably the most significant initiative in this regard is the 2003 New Freedom Commission on Mental Health. At the behest of President George W. Bush, this commission of experts surveyed extant US mental health services and wrote a report making a series of recommendations. The report noted that service delivery was fragmented and disjointed, which frustrated opportunities for recovery, and also noted that people with SMI suffered numerous inequities including very low rates of employment and overrepresentation among the homeless population. The commission argued that the system must be transformed to "ensure that mental health services and supports actively facilitate recovery" (Hogan 2003, p. 1), noting that "recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities" (New Freedom Commission 2003, p. 5). Specific commission recommendations include individualized care plans and increased access to evidence-based practices including supported employment and supported housing.

This set in motion the transformation of many public mental health systems to provide better recovery-oriented services, with many states (e.g., Connecticut) now providing quality recovery-oriented interventions such as supported employment and supported housing. That said, many other systems continue to fall short of "achieving the promise" of recovery, and there is an acknowledged need for further reform to make systems truly recovery oriented (Drake and Whitley 2014).

Other assertive governmental activities have gone some way towards promoting recovery. The 1990 Americans with Disabilities Act (ADA) prohibits discrimination against an individual with a physical or mental disability, ensuring equity in areas such as employment. The US Supreme Court confirmed that mental illnesses were covered by the ADA in the landmark 1999 Olmstead Decision, which upheld the right of people with SMI to live in the community, demanding an end to unnecessary segregation in institutional settings. The Department of Justice, backed by both the ADA and the Olmstead decision, is now working to ensure that states enact this right in practice. Other legislative efforts considered to foster recovery include the Patient Protection and Affordable Care Act (2010), which aims to improve quality and expand access to health care for people with mental and physical illnesses.

In recent years, the literature on recovery in the USA has diversified to encompass previously under-researched factors. Much emphasis has recently been placed on the importance of peer support for recovery (Davidson et al. 2012). A peer supporter is someone with lived experience of mental illness who draws upon his or her own experience to help others with mental illness progress in life. Peer supporters can be paid or unpaid. Research suggests that peer support is highly valued by people with SMI and can promote various aspects of recovery including treatment adherence, physical health and illness self-management (Druss et al. 2010; Chinman et al. 2014).

Other recent research has focused on the role of religion/spirituality in recovery. Some studies have found that religiosity and a personal relationship with God can assist in recovery, especially where a person with SMI simultaneously suffers from substance use disorder (Corrigan et al. 2003; Fallot 2001). This may be especially amplified in minority communities, for example, African Americans, who have traditionally been disenfranchised from formal mental health care systems (Whitley 2012) and who may experience higher levels of racial oppression and stigma (Armour et al. 2009; Leamy et al. 2011). Interestingly, the theme of psychotropic medications is absent from much of the recovery literature in the USA which takes a decidedly psychosocial, rather than biological, bent.

To summarize, notions of recovery within the USA are diverse, which is unsurprising given the size and heterogeneity of the country. That said, there are some commonalities running through the conceptualization of recovery therein. Firstly, much emphasis has been placed on living an autonomous, productive and meaningful life within the community. This correlates with culturally valued notions of "rugged individualism" and the "productive citizen" (Myers 2010). Secondly, evidence-based interventions that encourage and facilitate such independence, such as supported employment and peer support, are frequently labelled "recovery-oriented" (Whitley et al. 2012). Thirdly, societal efforts to promote recovery have been mandated by various governmental activities including the President's New Freedom Commission and the Supreme Court's Olmstead decision. Recovery as commonly conceptualized in the USA could thus be considered an individual journey towards autonomy, facilitated by independence-promoting psychosocial interventions and robustly enforced social justice legislation.

New Zealand

The origins of the user movement in New Zealand can be traced back to the mid-1980s, when mental health consumers began to organize and seriously question the values and philosophy behind traditional psychiatry, also demanding more input into mental health policy and practice (Gawith and Abrams 2006). Simultaneously, a Maori renaissance led to greater calls for the integration of Maori values into health care, specifically demanding a more holistic, family-centred, community-based approach to mental health (O'Hagan et al. 2012).

In response to this growing clamour for change, the New Zealand government commissioned a ground-breaking inquiry in the early 1990s into mental health services in New Zealand (Mental Health Commission 2004). The results of this inquiry were detailed in the 1996 Mason Inquiry Report, which noted high levels of stigma regarding mental illness and the need for mental health service reform. As a consequence, the government established New Zealand's Mental Health Commission, which was tasked with various activities, including the development of a national implementation plan to operationalize and monitor the Ministry of Health's mental health strategy national strategy (Human Rights Commission 2012; Mental Health Commission 2004). The commission engaged in significant consultation with key stakeholders, including service users, mental health organizations and Maori representatives.

In 1998, the Commission published the Blueprint for Mental Health Services in New Zealand, which was the operational plan, to outline its recommendations regarding the reform of mental health services. This was incorporated into subsequent policy (and funding frameworks) ensuring that locally grounded perspectives on reform were paramount (O'Hagan 2004).

This Blueprint was remarkable inasmuch as it was the first national-level governmental document to explicitly establish the recovery concept as central to future service delivery (Gawith and Abrams 2006). It states that recovery is "the ability to live well in the presence or absence of one's mental illness (or whatever people choose to name the experience)" (Mental Health Commission 1999). This overlaps with American definitions of recovery, stating that it is not synonymous with cure but more about quality of life. However, the Blueprint also expanded on American notions by explicitly highlighting social justice, social inclusion, citizenship and the countering of discrimination as integral to recovery (O'Hagan 2004; O'Hagan et al. 2012). The Blueprint explicitly states the importance of the incorporation of Maori perspectives on recovery, which uniquely shaped the development of the concept in New Zealand. Maori were consulted and their perspectives integrated throughout the drafting of the Blueprint, and in addition to integrating Maori perspectives throughout, there is a separate section devoted exclusively to recovery-oriented services for Maori.

As such, the definition, discussion and conceptualization of recovery in the Blueprint can in some ways be considered a reflection of New Zealand's underlying egalitarian and communitarian philosophy, heavily influenced by Maori perspectives. This could be placed in contrast to the earlier US-based notions of recovery that emphasized aspects of wider American philosophy (e.g., rugged individualism) through their emphasis on individual efforts and journeys towards recovery (Anthony 1993; Deegan 1997). Indeed, some in New Zealand explicitly argued that these American notions paid insufficient attention to the social, economic and political conditions that enable (or hinder) recovery. Others had semantic reservations about the word and its biomedical associations, and some professionals believed that American-derived notions of recovery lacked an evidence base (O'Hagan 2004; O'Hagan et al. 2012). As such, the Blueprint highlights the pivotal role of society and the community in fostering recovery, moving discussion beyond the role of individuals, clinicians and individual-level approaches to recovery.

In line with this communal approach, the government placed an emphasis on community-level anti-stigma initiatives that can diminish the social exclusion of people with SMI (O'Hagan 2004). This includes an ongoing $(NZD)11.7 million, five-year national programme named "Like Minds, Like Mine" aimed at reducing stigma and discrimination against people with mental illness. This involved a range of activities including television advertising campaigns, health care provider education and training, a national information phone line, contact-based workshops, promotional events to raise public awareness of stigma and discrimination, and advising organizations about how to ensure their policies and procedures are not discriminatory (Like Minds, Like Mine 2014). Research has shown this programme to be effective in reducing stigma and increasing public awareness of mental illness in New Zealand (Wyllie and Lauder 2012).

Though notions of recovery in New Zealand emphasize the role of society and the community, the New Zealand Mental Health Commission also recognizes the critical role played by clinicians in fostering recovery. As such, it has published competencies for mental health workers to foster recovery. According to this document, a recovery-oriented mental health worker (1) understands recovery principles and experiences (e.g., living well in the community with natural supports), (2) recognizes and supports the personal resourcefulness of people with mental illness, (3) accommodates diverse views on mental health issues, (4) has self-awareness and respectful communication skills, (5) actively protects service user's rights, (6) understands discrimination and social exclusion and how to reduce it, (7) knows how to work with diverse cultures, (8) supports service users to use community resources, (9) supports the user/survivor movement and (10) understands and supports family perspectives and participation (Mental Health Commission 2001).

These competencies have subsequently been used for a range of mental health service purposes, including quality improvement, job descriptions and performance appraisal (Lloyd et al. 2004; O'Hagan 2004). The publication and subsequent implementation of these guidelines represents an attempt to ensure that the principles of recovery are enacted in everyday services and professional practice. Furthermore, these core competencies, by highlighting domains such as social exclusion, patient rights and cultural issues, further solidify an approach to recovery that emphasizes communal and supra-individual-level variables in recovery.

In addition to the communal emphasis on recovery, notions of recovery in New Zealand have been heavily influenced by Maori notions of good mental health. These notions emphasize a balance between an individual, extended family, and the wider social and ecological environment (Lapsley et al. 2002). Family is also an important focus in Maori-influenced mental health, as many Maori believe that the extended family can be a source of strength, support, wisdom and identity (O'Hagan et al. 2012). These notions were incorporated into all of the New Zealand Mental Health Commission documents previously discussed, emphasizing Maori-inspired factors. It is important to note that although support for recovery in New Zealand has grown since the 1990s, some authors argue that recovery no longer has the same currency in New Zealand as it did previously and that policy and financial support for recovery may be weakening (O'Hagan et al. 2012).

To summarize, the recovery approach has become a fundamental part of mental health policy and services in New Zealand and represents a stretching of the notions of recovery developed in the USA. The New Zealand approach places a greater emphasis on the role of society and the community in fostering recovery, deriving from Maori-inspired values and the more communitarian nature of New Zealand society.

Nigeria

As in most LMICs, mental health services in Nigeria are underfunded and poorly resourced, and access to mental health services is difficult for the majority of Nigerians. A needs survey carried out by the WHO found that only 20% of people with SMI in Nigeria had received treatment in the preceding year (Wang et al. 2007). Mental health service provision is largely provided at publicly funded community-based general and teaching hospitals psychiatric units and at stand-alone mental hospitals, but often patients have to pay for services themselves out-of-pocket. Furthermore, service provision is majorly centred on biomedical interventions, whereas formal psychosocial interventions and ancillary professionals such as psychiatric social workers and case managers are often in short supply. Wide intra-country disparity exists in both the distribution of treatment facilities and availability of trained personnel, with most services focused on major cities and administrative centres, and rural areas experiencing the most deficits (WHOAIMS 2006). Mental illness stigma is high, as is caregiver burden (Gureje et al. 2005), a not uncommon finding in other LMICs.

Mental health service provision is not modelled on the consumer-driven mental health recovery model that is now dominant in the USA, UK and other parts of the English-speaking world. Rather, patient care still tends to rely more on the paternalistic "doctor knows best" model of care bequeathed by British colonial psychiatry. Until recently, mental health consumer and advocacy organizations were a rarity, thus, service users have not been directly involved in either the formulation or implementation of mental health policies or legislation at any time (WHOAIMS 2006). As such, patients often have little say in decisions as to choice of treatments and interventions. Treatment practices that undermine individuals' basic rights, autonomy and human dignity get reported in the media from time to time (Westbrook 2011). For example, in 2013, the Nigerian media published many reports that a state governor had orchestrated the forced detention in a psychiatric facility of his estranged wife who was in the process of initiating divorce proceedings against him, allegedly on grounds of domestic violence (e.g., Akukwe 2013; This Day Live 2013).

It would be reasonable to infer that such a treatment system would lead to worse population-level recovery outcomes. Yet surprisingly, there is indication of better illness and social outcomes of SMI in Nigeria as compared to the developed world. Nigeria is one of the sites of the WHO longitudinal studies of outcomes in SMIs that reported better long-term outcomes for patients (Jablensky et al. 1992; Cohen et al. 2008; Myers 2010), indicating yet-to-be-understood processes operating in the social environment that may influence recovery.

Nigeria's current mental health act, known as the Lunacy Act (1916), dates back to the colonial period. The Lunacy Act has provisions for an insanity plea, involuntary detention and standards for conditions within an asylum, but makes no mention of treatment. Last revised in 1958, the Lunacy Act has been criticized as outdated and "embodying a custodial approach to care, failing to protect human rights that persons with a mental illness are entitled to, and itself being responsible for certain abuses of human rights" (Westbrook 2011, p. 416).

In 1991, the Government formulated its first national mental health policy (FMOH 1991). Still in force, the national mental health policy covers advocacy, promotion, prevention, treatment and rehabilitation. The highlights include giving persons with a mental illness the same rights to treatment as individuals with physical illnesses, the integration of mental health into general health services at all levels, comprehensive care using primary health care (PHC) as a vehicle, combating stigma and periodic review of mental health legislation. The policy also includes a national mental health strategy centred on integration of mental health into the PHC system. While this policy is quite progressive and its spirit consistent with current dominant Western notions of a recovery orientation, recovery is not specifically mentioned or officially defined in the policy. Implementation of the policy has been impeded by governance issues, which include the absence of a dedicated mental health desk at the ministry of health to oversee implementation and the absence of a clear implementation plan (WHOAIMS 2006).

In addition to biomedical psychiatry, however, mental health care and support is also provided by religious and traditional healers, and although not funded by the state, these alternative providers are more ubiquitous and enjoy sizeable patronage from the populace despite the fact that the financial costs incurred by patients who use them can be significantly high in comparison to hospital care (Makanjuola 2003). In terms of their practice, the traditional and faith healers make use of combinations of the medical approach, traditional approaches such as offering sacrifices to ancestral deities and gods, and religious practices such as prophecy, trance and dream (Agara et al. 2008). Often, alternative providers hold illness explanatory models similar to those held by persons with SMI and their family caregivers, a point that has been held as positive and less stigmatizing. On the other hand, traditional practice is associated with a host of negative practices, including physical beatings and use of physical restraints on patients, practices incommensurate with Western notions of recovery (Makanjuola et al. 2000).

Given the poor state of mental health services in Nigeria, the question remains, what explains the relatively better social and functional outcomes of SMI in Nigeria as compared to the developed world? In other words, what recovery processes are in operation in Nigeria and other LMICs that are yet to be understood? Although the WHO studies used outcome measures deemed invariant across individuals and across a diversity of geographical settings, the critique has been made that the notion of recovery used in the WHO studies fails to fully capture recovery as envisioned in the user-consumer movement (Slade et al. 2008). WHO researchers cited “unexplained cultural factors” as a possible explanation for the better illness outcomes in LMICs (Jablensky et al. 1992). The better outcomes have also been ascribed to the coexistence of traditional care systems alongside biomedical (Western) psychiatric services available to individuals with a mental illness because practices of medical pluralism make it more likely that individuals will find treatments to which they respond (Halliburton 2004).

More recently, researchers have suggested as possible explanation the role of families in LMICs, as more accepting and supportive of individual members who develop SMI (Bresnahan 2003; Nunley 1998; Myers 2010). Cross-cultural studies of expressed emotion (EE) within families are a case in point. First used in the UK and the USA in the study of schizophrenia, EE has been used as a construct in understanding the interaction, feelings and emotions, between patients and their family caregivers (Bhugra and Mckenzie 2003). Cross-cultural studies of EE in families of persons with SMI, for example, suggest that in LMIC settings, family interactions with individual members who have SMI may evidence much more warmth and positive regard, with an absence of high levels of hostility and emotional over-involvement, two components of EE predictive of poor outcomes in the developed world (Bhugra and Mckenzie 2003). Families may also facilitate improved patient outcomes in LMICs in other ways. For example, a study at a Nigerian psychiatric hospital found that family involvement in treatment during hospitalization was independently associated with greater post-discharge appointment adherence in individuals with SMI (Adeponle et al. 2009). Bresnahan (2003) has suggested that family involvement, acceptance and support of individual members who develop SMI and community cohesion can be understood as contextually relevant practices and processes that reduce stress or increase resilience. They further argue that it is the stress reduction that families engender that possibly accounts for the better illness outcomes seen in LMICs (Bresnahan 2003).

It is important to recognize that family involvement is not always positive or necessarily geared towards the individual interests of the ill member (Cohen 2004). McGruder (2004) in a study of the lived experience of schizophrenia among patients and their family caregivers in Zanzibar (Tanzania) found that while family involvement is the explanatory link between low EE and better illness outcomes, family involvement was diverse and not always positive, and not uncommonly, families would subjugate goals of apparent personal relevance to family interests. McGruder (2004) concluded by noting that local notions about the nature of self, family and adversity mediate how family support is given. In other words, an individual's perception of family involvement may just be as important as the actual support.

Importantly, positive family involvement is consistent with aspects of the Western notions of recovery in that it is community based, emphasizes individuals' pursuit of personally relevant goals and instilling hope, and makes use of natural supports (Nunley 1998; Glynn et al. 2006). Thus, one may surmise that positive family involvement in care of persons with SMI, alongside related contextual factors such as less social exclusion and the availability of socially meaningful roles for persons with an SMI (Nunley 1998), plays a significant role in recovery in SMI in the Nigerian context, albeit in the absence of badly needed, currently absent recovery-focused mental health services.

In sum, it appears that in the Nigerian setting, opportunities for recovery occur in spite of a faltering mental health system. Recovery is realized through everyday practices of individuals with SMIs, their family members and caregivers that guarantee a social space within the larger society for persons with SMI. Importantly, these practices are simultaneously rooted both in "tradition" and in present-day sociocultural realities, a continuity that has relevance for efforts to fashion sustainable models of mental health care applicable across diverse cultural contexts (see Susser et al. 2010). In many ways, the current "new" definition of recovery being championed in Western countries may well be old wine in new bottles from the standpoint of individuals with an SMI in Nigeria, their families and caregivers. That said, undoubtedly the "new" recovery has a lot of good from which mental health service provision in Nigeria can fruitfully benefit. Of special importance is the recovery focus on guaranteeing full citizenship and civil rights for individuals with mental illness, including empowering self-advocacy and support for the fledging service user/consumer movement. In Nigeria, this will entail giving legal and political teeth to the issue of guaranteeing both legal and inalienable rights of persons with SMI, including protection against treatment coercion, rights to comprehensive care, adequate funding of mental health services and support for family caregivers.

Conclusion

The above three cases demonstrate different ways in which recovery is conceptualized and operationalized in a diversity of cultures and jurisdictions. In the USA, recovery is primarily conceptualized as the role of individual patients and their clinicians, reflecting dominant philosophies of individualism and the productive citizen. In New Zealand, greater emphasis is placed on a socially just society and a reformed community, which is posited to create favourable sociocultural conditions that foster recovery. This reflects New Zealand's more communitarian ethos as well as the Maori emphasis on ecological influences on health and wellbeing. In Nigeria, the work of recovery appears to occur in the everyday processes of the family, in spite of a faltering public mental health system and lack of official support.

Interestingly, the three case studies indicate that notions of recovery tend to emerge in a bottom-up manner from people with mental illness and family members. In New Zealand and the USA, these notions reflect deeply embedded cultural values. As time progresses, these notions of recovery have become broadly accepted as representing a desirable foundation for the advancement of people with mental illness in these countries. These notions have then become co-opted by the respective countries' Mental Health Commissions and then officially mandated and embraced by governments and mental health services therein. In Nigeria, bottom-up notions of recovery have not been co-opted and officially embraced, but still remain embedded within families and people with mental illness.

Though there are differences in emphasis, there are core commonalities across the notions of recovery discussed in this book chapter. In all three case studies discussed, recovery is indicated and facilitated by (1) ensuring that people with mental illness can fully participate and thrive within their respective societies; (2) diminishing barriers to social inclusion and full citizenship at the individual, familial and community level; and (3) reforming mental health services so that they are humane, empowering and holistic.

The local, consumer-driven approach that is at the heart of recovery is arguably missing from much of the GMH discourse today. A 2011 publication in *Nature* identified “grand challenges in global mental health”, outlining GMH research priorities for the next ten years (Collins et al. 2011). This publication sparked much debate among mental health researchers about the appropriate methods for establishing priorities, research themes and interventions in GMH. Critics strongly oppose the GMH movement for its alleged top-down approach, just as recovery researchers have noted that notions of recovery must be grounded in local realities of everyday life, including the familial, sociocultural, religious and economic activities that make the world intelligible (Summerfield 2002). Vikram Patel, seen by many as the key champion of the GMH movement, and colleagues have argued that the GMH movement is consistent with recovery models, as it strives to create GMH systems that are “effective, equally distributed, affordable, and appropriate to the local social and cultural context” (Patel et al. 2014, p. 162). However, critics of the GMH movement have noted that consumer involvement has been lacking in setting the agenda and that this movement is largely a top-down professionally led approach (Summerfield 2002). Conversely, modelling a bottom-up approach, the World Network of Users and Survivors of Psychiatry (www.wnusp.net) is a consumer-led organization that works to confront global imbalances of power by advocating for the human rights of people with psychosocial disabilities internationally. The debate around the GMH movement and whether it is truly conducive to recovery-based interventions is not easily resolved. What can be concluded is that the concept of recovery as examined in this chapter has been developed in a bottom-up manner, largely driven by consumers and tailored to local circumstances and cultural values. Jurisdictions attempting to provide or implement new recovery-oriented services should proceed mindful of this process.

As the GMH movement expands, other nations will likely wrestle with reformulating, advancing and enacting the rights of people with mental illness. This may take the form of new mental health commissions, new mental health acts, societal anti-stigma initiatives and reform of services. This book chapter indicates that the recovery model may well be a useful heuristic for inspiring reform at all levels in a plurality of nations. It provides enough scaffolding to give meaningful shape to reform, while allowing flexibility for cultural and social adaptation to local circumstances and values. It is our hope that recovery will continue to be taken seriously as a reform-driving concept throughout the world.

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7

Positive Mental Health and Wellbeing

Sarah C. White and Carola Eyber

The past 20 years have seen an explosion of interest in positive approaches to mental health, happiness, and wellbeing. While these concepts vary considerably from one another, they share an optimistic charge and an identification of people as active subjects rather than passive patients. They are also characterised by a broader understanding of what constitutes mental *health*, marking a shift from the minimal definition of an absence of mental *illness* to a more expansive emphasis on optimal psychological functioning and/or a fulfilling experience of life (Westerhof and Keyes 2010).

This focus on happiness and wellbeing acts as a bridge between Global Mental Health (GMH) and the broader arena of national and international policymaking. First, the promotion of happiness itself is seen as the proper *purpose* of policy. In the UK, one of the primary proponents of 'happiness economics' has thus argued strongly for greater government investment in mental health, and particularly cognitive behavioural therapy (CBT) (Layard 2006). Globally, the Government of Bhutan has gone furthest in seeking to incorporate happiness as a national development target, and spearheaded a successful move for the United Nations to adopt a 'Happiness Resolution'

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in 2011. In addition, subjective measures of wellbeing are increasingly seen as suitable *indicators* of wider policy success. Canada, Australia, and New Zealand were joined by the UK in 2011 in incorporating subjective measures of well-being in national census surveys. The Organisation for Economic Co-operation and Development (OECD) reported in 2013 that France, Italy, the United States, the Netherlands, Japan, and South Korea were also either using or planning to use such measures.

Although the positive charge of 'wellbeing' attracts wide-ranging assent, this is by no means universal. Critiques of more positive approaches to mental health are launched from both conservative and radical perspectives. Some distrust the breadth and 'fuzziness' of the notion of wellbeing, preferring the greater precision of clinical diagnoses of mental illness. Another fear is that the wide scope of 'wellbeing' as a focus of governmental concern—and supported through a plethora of voluntary and private sector organisations—legitimates an ever-greater intrusion of the state into the personal lives of citizens. Alternatively, concerns are raised that the stress on personal responsibility for positive mental health could be used to justify the withdrawal of state services or welfare support, or represent ideological pressure to say that they are 'happy', rather than engage in a struggle for social change.

As is described later in the chapter in more detail, the dominant approaches to subjective dimensions of wellbeing are also subject to conceptual and methodological critique. In the global context, a major issue is the tendency still to consider positive mental health as a property of individuals. This has been criticised as reflecting a culturally—and some would say ideologically—specific identification of personhood. Similarly, it has been argued that the character of mental health and psychological processes needs to be understood in relation to, rather than in abstraction from, the wider social context. Researchers of wellbeing in the Global South have gone further to argue that material, relational, and subjective dimensions of 'the good life' are profoundly intertwined (Gough and McGregor 2007; White 2010). Perspectives on wellbeing from indigenous peoples, such as the Maori or Australian aborigines, the Adivasis in India, or the so-called Indios in Latin America, tend to be the most holistic, emphasising relations of moral reciprocity between human communities, other forms of life, the earth, and divine powers (McCubbin et al. 2013, McGregor et al. 2003, Panelli and Tipa 2007, Rodriguez 2015, Wilson 2003).

This chapter provides an opportunity to explore themes that are germane to the study of the concepts of mental health and wellbeing. We begin by sketching out some of the trajectories across different academic and policy fields that have contributed to the current emphasis on positive mental health and wellbeing. We then introduce the key concepts of 'subjective wellbeing' and 'psychological wellbeing' and describe some of the methods by which these are assessed. We consider what the two approaches have in common and how they differ. We then discuss some of the main criticisms that are levelled at them. The chapter closes by considering two very different ways that positive approaches are being pursued in policy and practice in the Global South: psychosocial wellbeing in the context of disasters and humanitarian crises, and political mobilisation around notions of 'living well' in Latin America.

A Brief History of Happiness and Wellbeing Studies

The ubiquity of current appeals to happiness and wellbeing suggests that they reflect a range of different interests and cultural trends. Within psychology, they are led by the positive psychology movement, launched by Martin Seligman in 1998 during his presidency of the American Psychological Association. This builds on a longer history of humanistic psychology which includes figures such as Marie Jahoda (1958) and Abraham Maslow (1954), both of whom argued for a positive emphasis on mental health against the overwhelming preoccupation with mental illness. In Western popular culture, the emphasis on happiness and wellbeing chimes with the rapid expansion of counselling and psychotherapies, and the normalising of these as forms of life-coaching and aids to personal growth, rather than simply treatment to address dysfunction (e.g. Rose 1989; Illouz 2008). This is paralleled by a psychological and affective turn in academic social science which has seen a rapid expansion in the attention paid to intra-psychic processes amongst sociological, anthropological, and economic scholars (e.g. Connell 2005; Craib 2002; Frey 2001; Kahneman 2012; Lutz 1998; Mama 2002; Moore 2007).

A rather different trajectory is evident at the macro level. Here, recognition of environmental 'limits to growth' (Meadows et al. 1972) has spawned reconsideration of economic models that identify human wellbeing with increased consumption, and suggestion of the need for new—or perhaps a return to older—models of human flourishing (e.g. Alkire 2002; Deneulin 2014; Jackson 2005, Kasser 2009; Li and Xioa 2011; Martínez-Alier et al. 2010). This has come together with an associated set of calls to move 'beyond GDP' in national and international measurements of economic and social progress (e.g. OECD 2013; Stiglitz et al. 2009; Sen 1999). It also has affinities with the 'capability approach' of Amartya Sen, which has made a major contribution to placing wellbeing on the global economics and international development agenda. This developed as a critique of measuring standards of living either by what people have (commodities) or by the pleasure or happiness they derive from these (utility) (Sen 1983). Instead, the concept of capability focuses on the individual and 'the alternative combinations of things a person is able to be or do' (Sen 1993, p. 30). Sen counts the ability to be happy amongst 'important functionings', but resists the suggestion that being happy is the sole or pre-eminent purpose of human life (Sen 1993, p. 37). Like the psychological wellbeing (PWB) approaches described below, he also emphasises agency and freedom as both prerequisites for and constituents of wellbeing.

Connections looping back from macro-economic to individual measures of positive mental health are made by the burgeoning 'economics of happiness' literature. This follows Easterlin's (1974) discovery of the 'paradox' that, while within a given country wealthier people tend to report being happier, rising GDP over time in the United States does not correspond with higher levels of happiness. This finding has been widely and hotly contested, but an incontestable outcome of the subsequent debate is that 'happiness' has become a serious topic for discussion in policy and economic communities (e.g. Deaton 2012; Dolan and White 2007; Graham 2012; Helliwell et al. 2013; Layard 2005; Stevenson and Wolfers 2008; Thin 2012).

As mentioned above, the Government of Bhutan has become the global standard-bearer for the promotion of 'Gross National Happiness' (GNH). Inspired by a throwaway comment of the King of Bhutan in 1972, both the idea and the measures of GNH have been reworked many times, making it a truly 'glocal' project, seeking to meld ecological awareness and Bhutanese 'wisdom' together with standard development and Western 'science of happiness' scholarship. 'Happiness: Towards a New Development Paradigm' (NDP 2013), produced by 'an international expert working group' for the Government of Bhutan in December 2013, exemplifies this mix. Standard development concerns with living standards, health and education, and environmental sustainability appear alongside the values of service, interconnectedness, and co-operation. Since 'the inner transformation of our own mind-sets and behaviours is as important for happiness as the transformation of these outer conditions of wellbeing' (NDP 2013, p. 34), it recommends in addition 'happiness skills' 'drawn creatively from human historical experience, wisdom traditions, and modern science' (NDP 2013, p. 20).

The new focus on happiness and wellbeing thus draws on established traditions in humanistic psychology and welfare economics, but it does so with a new twist. While the earlier traditions were significantly philosophical and discursive, both positive psychology and happiness economics are positivist and empiricist in orientation, their arguments grounded in statistical manipulation of large datasets, with claims buttressed by appeals to 'science' (e.g. Diener 2000, Layard 2005). As discussed later in the chapter, this has not gone unchallenged. There are many questions about the robustness of the data, the limitations of quantitative methods, the ways happiness and wellbeing are conceptualised, and the ideological politics involved.

Key Concepts and Methods

Subjective Wellbeing

In some ways, the simplest notion is 'subjective wellbeing', or SWB. This is a means of measuring how happy people are in and with their lives. Amongst psychologists, SWB is typically conceptualised as a composite of life satisfaction, derived through 'cognitive' thought or reflective processes and 'affect balance' which refers to emotions or feelings. It is proposed that affect needs to be measured along two dimensions (positive and negative) as the presence of negative emotions is not equivalent simply to the absence of positive ones (Keyes 2005).

In economics, SWB tends to be conceptualised simply as life satisfaction. Many more recent analyses (e.g. Diener et al. 2010) lead to questioning whether life satisfaction and asset balance should be considered together, since they behave rather differently in statistical tests. Life satisfaction tends to correlate with people's economic standard of living, affect balance with their social and PWB (Graham 2012).

Life satisfaction measures tend to be quite simple. Especially in economic surveys, a single item may be used as an indicator of 'global happiness'. The Gallup World Poll, which is probably the most widely used source of international data on wellbeing, employs just two items to gauge present and anticipated future life evaluations, leading to classification of respondents as 'suffering', 'struggling', or 'thriving' (Gallup, n.d.). Diener's widely used 'Satisfaction with Life Scale' (Diener et al. 1985) has five items. An alternative approach is to measure satisfaction across various life domains. The Personal Wellbeing Index (PWI) thus asks people to rate their satisfaction with their standard of living, personal health, achieving in life, personal relationships, personal safety, community-connectedness, future security, and spirituality–religion (International Wellbeing Group 2013)

Measures of affect are much more diverse. These aim to rate the frequency with which people experience 'positive' versus 'negative' emotions.[1] This might involve self-assessment against a standard list (e.g. the PANAS scale, Watson

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[1] Whether it is useful to characterise emotions as 'positive' or 'negative' is itself open to debate, of course.

et al. 1988). Alternatively, respondents might be asked to recollect emotional experiences which are then categorised as positive or negative, by either themselves or others. Although at one level there is acceptance that this is subjective data on which the respondent must be the ultimate authority, there is a lingering unease with this amongst these scholars, who are predominantly positivist in orientation. 'Experience-sampling' thus aims to collect immediate ratings of emotions as they are experienced—respondents are buzzed or otherwise prompted to record what they are feeling right at that moment (e.g. Larson and Csikszentmihalyi 1983) to avoid the deviations of memory. Researchers sometimes recommend triangulating subjective accounts with 'objective correlates', such as recording how often people smile (Nettle 2005). Ultimately, the aspiration towards 'science' may lead towards by-passing altogether the need to engage with the subject who thinks and feels to express him or herself as brain imaging technologies provide 'objective' means to assess happiness (e.g. Berridge and Kringelbach 2011).

The attraction of SWB is the extent to which it is parsimonious: it provides a one-off assessment of people's subjective success in life. For economists and the policy community, it is seen to provide a direct, quantifiable measure of utility—instead of having to rely on income or consumption as a proxy measure of wellbeing; it is claimed, it is now possible to assess people's happiness directly. Moreover, its advocates claim that it is culture-free, since people make their own judgements by their own criteria—there is no attempt to state what happiness means, but simply 'how happy' people are. This means, it is claimed, that SWB can be used to compare the net effect in terms of increased happiness across very different interventions, or indeed government policy as a whole. The OECD (2013, p. 36) gives an example of this position:

> being grounded in peoples' [*sic*] experiences and judgements on multiple aspects of their life [*sic*], measures of subjective well-being are uniquely placed to provide information on the net impact of changes in social and economic conditions on the perceived wellbeing of respondents.

In practice, there are serious doubts as to whether SWB can indeed deliver the benefits to policy that are claimed for it. Even if you set aside the considerable difficulty of representing your life through a single figure, people tend to experience such questions as asking them to rate themselves—a very sensitive issue. 'Social desirability bias' means that people respond with how they would like to be perceived, rather than what they are actually feeling. SWB measures have also shown themselves to be very sensitive to the instruments which generate the data. For example, Deaton's (2012) assessment of SWB amongst Americans during the economic crisis finds that a large proportion of the variability of scores from year to year is accounted for by changes in the order in which questions were asked. Frey and Gallus (2013) also point out that if SWB is adopted as an indicator of governmental success, it will become subject to political manipulation—by both government and voters. Finally, of course, the 'emptiness' of SWB means that the link between a policy or other event and a rise or fall in scores is by no means transparent.

Psychological Wellbeing

By contrast with SWB, proponents of PWB do focus on the substantive content of what constitutes positive mental health or 'optimal psychological functioning'. Carol Ryff in particular seeks to re-engage the theoretical tradition of humanistic psychology which she sees as having been marginalised by its lack of empirical measures (Ryff 1989). The starting point of PWB theorists—and the core of their objections to SWB—is that what makes you *feel* good may not necessarily *be* good for you. What matters is not simply pleasure but fulfilment. They therefore critique the SWB approach for being 'hedonic' and identify themselves as 'eudaemonic', following in the Aristotelian tradition. For Ryff (1989, p. 1070), this is about 'the important distinction between the gratification of right desires and wrong desires'. For Ryan and Deci (2001, p. 146), what matters is not just pleasure but 'the striving for perfection that represents the realization of one's true potential'. Interestingly, Martin Seligman (2011) has recently also come to criticise his earlier emphasis on 'authentic happiness' and endorse instead a broader 'construct' of 'wellbeing'.[2]

Ryff set out to establish a model of PWB which could be empirically assessed across six domains (Ryff 1989; Ryff and Keyes 1995). These six domains are self-acceptance (a positive and acceptant attitude), purpose in life (goals and beliefs that affirm a sense of direction in life), autonomy (self-direction guided by socially accepted internal standards), positive relations with others (satisfying personal relationships), environmental mastery (capability to manage complex environments), and personal growth (insight into one's own potential for self-development) (Ryff and Keyes 1995).

By contrast, Ryan and Deci's project was a theory of motivation, 'Self-Determination Theory (SDT)', which emphasises the psychological importance of intrinsic motivation—doing something for its own sake, rather than for the sake of getting some other reward. SDT maintains there are

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[2] Seligman (2011, p. 12) characterises well-being as a construct made up of: positive emotion, engagement, positive relationships, meaning, and accomplishment.

three universal psychological needs: competence, autonomy, and relatedness. Rather than theorising PWB directly, therefore, it is seen as an outcome of meeting these needs. Much of the controversy surrounding their approach has centred on the concept of autonomy, and whether this is genuinely a universal need, or one that reflects the theorists' particular cultural location in the affluent United States. In response, they define autonomy in opposition to heteronomy or control by others, arguing that this frees it from any primary association with individualism (Ryan and Deci 2011).[3] Unlike Ryff, who is openly hostile to SWB approaches, they maintain that SWB (which they define as life satisfaction plus feelings of happiness) represents one possible indicator of positive psychological health, but only one. More importantly, 'assessments of self-actualization, vitality, and mental health … assess wellbeing conceived of as healthy, congruent and vital functioning' (Ryan and Deci 2001, p. 147).

Ryff's six domains and Ryan and Deci's three psychological needs can be assessed in a number of different ways, but none has the simple portability of SWB. By contrast, the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) comprises just 14 questions (or 7 in the short version) about mood, energy, and cognitive functioning. As a framework this does not have the theoretical ambitions of either Ryff and Keyes or Ryan and Deci, but instead comes much closer to a conventional, diagnostic understanding of mental health. This is perhaps not surprising given that it was developed in partnership with the Scottish National Health Service (Tennant et al. 2007). It does, however, manage to avoid the widespread tendency of health-oriented frameworks to slip into negative measures which actually focus on mental illness.

Critiques of PWB concentrate largely on its cultural content. Diener et al. (1998, p. 35) charge it with being anti-democratic, since the definition of what matters is determined by experts whereas SWB allows people to assess satisfaction and happiness by their own criteria. Ryff's representation of the six domains, which sets out a mini profile of high and low scorers is particularly vulnerable to charges of cultural bias, compared with the more abstract and therefore more culturally accommodating core of the SDT. Ahmed (2010, p. 12) presents instead a sociopolitical critique of eudaemonic approaches to well-being, that the notions of 'higher' and 'lower' forms of wellbeing on which they depend are vulnerable to class, ethnicity, and gender bias, as 'hierarchies of happiness may correspond to social hierarchies'.

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[3] See Miller (2002) for a helpful discussion of the individualism/collectivism binary that has dominated cross-cultural psychology.

Critiques

As presented above, there are clear and significant differences between SWB (i.e. a measure for assessing the subjective success of a life) and PWB (a more substantive way of understanding what it means for a human being to flourish). However, it is also important to recognise the commonalities between the concepts which derive from their shared disciplinary grounding in North American quantitative psychology. First, they both have an unquestioning commitment to a methodological and ontological individualism. The individual is the unit of analysis, and the individual is psychological, *affected by* the material, social, and cultural milieu but not fundamentally constituted through these. This is typically criticised in terms of a *cultural* bias, drawing attention to the fact that people in other geographical locations see relationality as fundamental to personhood (e.g. Christopher 1999; Christopher and Hickinbottom 2008). While there is a cultural dimension to this, it is also a *disciplinary* bias. Qualitative sociological work approaches subjectivities of wellbeing as much more fluid, provisional, and relational constructions, a matter, to quote Atkinson (2013), of 'assemblages' rather than 'components'. Indeed within psychology itself, feminist writers such as Mama (2002) and Benjamin (1988), along with the whole tradition of psychoanalysis, clearly contest simplistic models of personhood that are mobilised by positive psychology. The key issue here is whether it is such a simple thing to know and speak one's true feelings or make an assessment of one's life.

Secondly, both PWB and SWB are governed by the culture and institutions of statistical research: disciplinary rules about the generation of data, forms of analysis and model validation, and the reporting of results. This builds in a conservative bias, not necessarily in terms of ideological politics, but in the logic of research. For example, scales that have already been 'validated' raise fewer questions from potential reviewers and conventional measures allow comparison with other studies and contexts. This betrays a structural commitment to universalist approaches over contextual ones: a scale 'proves' itself by being 'validated' in multiple settings. But the fact that people can be induced to respond to a given scale does not mean that it necessarily reflects anything about how they actually think about their lives. This construct validity can be present but relevance and meaning relatively absent. And the strong bias towards existing measures limits the potential for innovation and restricts the scope for something quite unexpected to be discovered.

Thirdly, and following on from this, the dominant methods used in such research—closed questions or statements which are answered on a Likert scale—are highly limiting and disciplining to respondents. Ordinary people in most parts of the world do not live their lives in the general, but the particular, not in the abstract, but the concrete and embodied. However sensitive one seeks to be in reflecting the contexts in which lives are lived (and the rules of the game as set out in the previous paragraph place strict limits on this) the structure of these questions and their requirement to abstract from and generalise about one's life are very far from the 'natural' way that people choose to express themselves (White and Jha 2014). You cannot capture the texture of the lived experience of wellbeing through a number on a scale of 1–10! Schwarz (1999) argues persuasively how 'the questions shape the answers' in questionnaire research, because respondents seek to pick up from the structure and format exactly what is required. This raises the question as to whether the relative stability of SWB [Cummins (2009) reports a global norm of around 75%] might be as much a property of the scale—people's choice to represent themselves as happier rather than unhappier but not ecstatic—as a reflection of inner feelings. In addition, average scores vary according to whether cultural norms encourage positive (ideal-type North American) or modest (ideal-type East Asian) statements about the self (Diener et al. 2000). Differences in average levels of response across societies might thus not tell us anything about people's actual 'happiness', but rather social and cultural norms about the 'presentation of self' (Goffman 1959).

Going one step further, it is possible to see how the fact of undertaking a survey itself is placing strict limits on what you can and cannot discover: you can only allow what will fit the categories you have pre-determined. Qualitative methods that allow people to define their own categories or to present their well-being without such prescribed classifications provide openings for exploring how people present their lived experiences (Camfield et al. 2009; White and Jha 2014). Ethnographic methods, for example, facilitate opportunities for researchers to gain insight into complex emic perspectives on wellbeing and mental health (see also chapter 10 by Mills and White in this volume).

Fourthly, their commitment to the individual as unit of analysis severely limits the ability of these approaches to recognise the social and political. Seligman (2011, p. 16) provides an extreme example of this, as with extraordinary naivety he characterises his (new) wellbeing theory as:

> essentially a theory of uncoerced choice and its five elements comprise what free people will choose for their own sake.

As the work of Lukes (1974) and many others shows, 'choices' are never completely 'free' but reflect values, preferences, and opportunities, all of which are shaped and made available or unavailable to different kinds of people through complex social and political processes. The social and political context also constructs differential aspirations and feelings of satisfaction or acceptance (Appadurai 2004). High scores may reflect the low expectations of internalised oppression, rather than genuinely positive experience. This also affects the ratings of the same individuals over time. The use of subjective measures in policy evaluation is bedevilled by 'adaptation'—the way that expectations shift with experience.

Choice is also foundational to SDT through its stress on autonomy:

> Autonomous self-regulation is central in allowing the individual to choose and most fully develop preferred ways of being, and in doing so to satisfy basic psychological needs which in turn lead to vitality and happiness. (Ryan and Deci 2011, p. 45)

The importance of a sense of autonomy or personal agency to wellbeing is not in doubt. The issue is how this is conceived. Devine et al. (2008) consider whether autonomy emerges as significant to wellbeing in various pieces of research in Bangladesh, as an example of an environment which is poor in material resources but relationally dense and rich. They find that autonomy is important, but suggest that this is expressed through:

> a complex array of situated autonomies that embrace a wide range of covert as well as overt behaviour patterns, decisions, and actions. (Devine et al. 2008, p. 28)

Importantly, they go beyond the individual to argue:

> autonomy is determined not only by the agential capacities of an individual but also by the nature of relationships he or she may enjoy with others. (Devine et al. 2008, p. 28)

Underlying all of this are epistemological questions about whether any approach to wellbeing can serve across all contexts, and ontological questions about the role of culture in the formation of personhood. Such questions apply, of course, to all characterisations of mental health or illness which claim to be universal. Obeyesekere (1985, p. 134) poses the problem neatly:

> Faced with generalised feelings of loss and sense of hopelessness labelled depression in the USA, in Sri Lanka [we] would say that we are not dealing with a depressive but a good Buddhist.

Similarly, Fernando (2012) recounts her encounter with a Tamil woman who had been tortured by the Sri Lankan military. Her lack of distress was interpreted by Fernando to be the process of psychological denial. When asked what the torture experience meant to her, the woman replied: 'Well, I am *really* looking forward to my next life. I must have done some terrible things to have deserved this horrible suffering. I know that in my next birth I will have the most wonderful life. This knowledge makes me happy' (Fernando 2012, p. 397). Constructs of the experience and meaning of distress and mental health and illness cannot be understood through a universalist framework but are instead intertwined with context, culture, and beliefs of people and societies.

While theorists of PWB may recognise the importance of the social, material, cultural, and political environment in promoting, supporting, or undermining autonomy, this is conceived as an external relationship, in the mode of 'the social determinants of health'. Such a framing cannot capture the ways that constructions of well-being or happiness are themselves implicated in relations of power. And yet this is critical if we are to understand what people are saying as they respond to the questionnaires. As Ahmed (2010, p. 5) points out, the context of happiness research is anything but neutral. If happiness is what everyone wants, then to be asked how happy you are is a very loaded question. Furthermore, if analysis centres on the individual, where is the space to consider

> feminist critiques of the figure of 'the happy housewife,' black critiques of the myth of 'the happy slave,' and queer critiques of the sentimentalization of heterosexuality as 'domestic bliss' ….which expose the unhappy effects of happiness, teaching us how happiness is used to redescribe social norms as social goods. (Ahmed 2010, p. 2)

The ideological character of the promotion of happiness is similarly criticised by Held (2002) who talks of the 'tyranny' of the positive attitude and Ehrenreich (2009) amongst many others. Fernando (2012), in his reflection on the GMH research agenda, makes a different kind of critique as she questions who benefits from the focus on the suffering of communities in 'low-power' countries such as Sri Lanka: GMH researchers and their institutions benefit, journals who publish the findings, the research community as a whole, and the funders gain from the research. Notably less obvious is the benefit that participating communities themselves derive from these large-scale research studies on mental health and wellbeing, and Fernando argues that community benefit and wellbeing is as important as individual benefit.

Psychosocial Wellbeing

Having considered the two dominant framings of wellbeing, both of which ultimately rely on abstracting the individual from his or her social context, we now turn to approaches which seek to develop a more collective and contextual approach. We consider first psychosocial wellbeing, particularly in the context of international development, humanitarian, and post-disaster rehabilitation. We then look at Latin American approaches to promote *buen vivir,* 'living well'.

The first psychosocial approach we introduce here is called 'inner wellbeing', developed through research in India and Zambia (White et al. 2014; www.wellbeingpathways.org). This began with the definition: 'Wellbeing is experienced when people have what they need for life to be good'. This places subjectivity at the centre, linking together experience, resources, needs, and evaluation. It is phrased in collective terms, but is also open to individual interpretation. The research aimed to explore the interplay between the experience of wellbeing and the external conditions in which people live their lives. Within this general approach, the psychosocial conception of wellbeing is termed 'inner wellbeing', which is defined as 'what people think and feel they are able to be and do'. Inner wellbeing is a domain-based model, comprising seven interrelated domains.[4] Its psychosocial orientation means that it emphasises people's grounding in and interaction with a particular social and cultural context, rather than internal psychological processes.

Whereas the concept of inner wellbeing was developed through an academic research project, an operational approach to psychosocial wellbeing has also been constructed as an alternative to mental health responses to humanitarian emergencies. Mental health approaches—which were dominant in humanitarian aid circles for several decades—are associated with a biomedical and psychiatric orientation to understanding the impact of conflict on people (Pupavac 2006). Post-traumatic stress disorder (PTSD) scales became a common means of assessing the impact of distress on populations and interventions were based on Western psychological and psychiatric theory and practice. Known as 'the trauma discourse' and associated with an orientation towards identifying disorders (PTSD, depression, anxiety) and vulnerability, the approach was criticised for imposing an alien view of mental health on people who were not asked about how they understood and identified their own wellbeing needs and priorities (Summerfield 1999). This

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[4] The inner well-being domains are economic confidence, agency and participation, social connections, close relationships, physical and mental health, competence and self-worth, values and meaning.

clinical approach to providing mental health services was seen as being culturally insensitive and largely contextually irrelevant for affected populations. It was partially in response to this that groups of practitioners and academics developed an alternative conceptualisation focused on psychosocial wellbeing (Psychosocial Working Group 2003). The main differences between the trauma and the psychosocial approaches were that the latter aims to be holistic in its understanding of the emotional, social, physical, material, spiritual, and political needs of affected populations. Psychosocial wellbeing was understood to be related to three domains: firstly human capacity, secondly social ecology, and thirdly culture and values. According to the *Psychosocial Working Group* (which was established in 1998), any initiative aimed at improving any of these three domains could thus be seen as a psychosocial intervention. For example, the exhuming of mass graves, forming a knitting group, working with a community to establish a football field could all be seen as activities that improve psychosocial wellbeing. This 'anything goes' approach was criticised by trauma-oriented professionals some of whom maintained the need for training and supervision of counsellors and therapists as the appropriate provision of mental health services (Hubbard and Pearson 2004). A further distinguishing feature of the psychosocial wellbeing approach is the emphasis on the material and socio-economic aspects of wellbeing, on the basis that it may be difficult to discuss emotions when you are thinking about how to feed your hungry children that evening. The focus on the intra-psychic as separate and disconnected from the rest of life (physical, material, social) is criticised as an artificial and theoretical distinction that has little relevance to how people think of their lives (Miller and Rasmussen 2009).

The development of the Interagency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support (2007) have contributed to a reduction in the tensions between the psychosocial and psychiatric paradigms by establishing the contributions that each can make for different segments of the population. The IASC interventions pyramid describes different levels and types of service provisions that fulfil functions for various groups of the population: the majority of people cope with their experiences without the need for additional interventions if security, basic service provision and local forms of support are re-established. A small minority who are suffering from mental illness need to receive specialised psychological or biomedical treatment. The rest of the population falls somewhere between these two ends of the continuum and may benefit from focused, non-specialised assistance in the form of support groups, psychoeducation, or various forms of psychosocial training (Wessells and van Ommeren 2008). Mental health and Psychosocial Support (MHPSS) has now come an established way to refer to the whole field. Commentators have however highlighted persisting tensions that can emerge when a disaster or emergency situation has occurred and the MHPSS 'circus' is mobilised (Pupavac 2006).

Partly in reaction to the perceived conservatism of SWB, psychosocial wellbeing has positioned itself at the progressive end of the continuum with the potential to be oriented towards accountable service provision. Its proponents have often situated themselves within a political and human rights agenda that sees its role as supporting people's own initiatives at rebuilding their lives. This, of course, does not mean that the potential is always realised; however, the discourse and the possibilities it creates allow for context, local agendas, and power issues to be brought to the fore of discussions about the appropriateness of mental health interventions in emergency settings. It also bears some resemblance to recent initiatives for recovery from mental illness to be defined by the service users themselves rather than having this defined by clinical and medical staff on their behalf (see chapter 6 in this part by Aldersley et al.).

Popular Mobilisation for Wellbeing: *Buen Vivir* in Latin America

All the approaches reviewed so far have been developed 'top down' by academics or professionals. By contrast, in Latin America alternative conceptions of what it means to live well have been the focus of grass-roots mobilisation from 'bottom up'.[5] These combine an emphasis on social and economic rights with the cosmologies of specific indigenous peoples, which tend to emphasise oneness, with humanity as part of nature and social relations intertwined with environmental relations. They also tend to be systemic or cyclical in orientation, rather than linear, to emphasise reciprocity, and to emphasise place and particularity rather than aspiring for 'global' universality:

> Living well, is life in plenitude. Knowing to live in harmony and equilibrium; in harmony with the cycles of mother earth, the cosmos, life and history, and equilibrium with all life forms in permanent respect. (Mamani 2010, in Rodriguez 2013)[6]

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[5] Buen vivir is the Spanish term for 'living well'. Alternative terms are also used, which express allied concepts in indigenous languages.

[6] Fernando Huanacuni Mamani (2010). 'Buen Vivir/Vivir Bien Filosofía, políticas, estrategias y experiencias regionales andinas'.

Translated as 'living well together'[7] these representations of indigenous ideologies have had a major effect in giving form to rights-based struggles against the dominance of traditional political elites, the United States, and neo-liberal capitalism, especially in Ecuador and Bolivia, where they have been incorporated into new national constitutions. The result is a new emphasis on the claims of the natural world and environmental sustainability, the need for redistribution and expanded state welfare provision, and the collective rights of marginalised peoples to inclusion within a state that recognises within it the equal rights of a plurality of cultures and nations (Radcliffe 2011). Rodriguez (2013) presents the components of Ecuador's plan for Buen Vivir (2009–2013). These comprise rights to the satisfaction of human needs; quality of life; dignified death; to love and be loved; healthy development of all in harmony with nature; indefinite prolongation of cultures; free time for contemplation; and the emancipation and widening of liberties, capabilities, and potentialities.

While the theory is attractive, the practice is more difficult. In reality, both Ecuador and Bolivia remain heavily dependent on mining, oil, or gas extraction with high environmental costs. Views of what it means to 'live well together' vary both between and within indigenous groups (Artaraz and Calestani 2014, Loera-González 2015, Rodriguez 2015). There are serious conflicts of interest between different geographical and occupational groups, and between environmental protection and the financing of social welfare or the provision of water and sanitation to the urban poor (Fabricant 2013). There are also international dimensions. For any country, it is a challenge to implement a radically different economic model given people's pressing needs, the daily politics of reforming state structures and the need to engage with global economic structures and relationships (Radcliffe 2011).

For some readers, we suspect, this direct engagement with politics seems a long way from GMH. As other chapters in this volume make clear, however, GMH is a political issue. In addition, at least in their core visions, *buen vivir* approaches represent a holistic approach to well-being that specifically resists the separations of mind, body, spirit; human and non-human; personal and political that all of the other approaches that we have reviewed are prey to. It also draws attention to the importance of communities being able to negotiate and work with their own cultural conceptions of what living well means, rather than having an external, perhaps medicalised, model imposed upon them. While it is clearly much more than this, we would argue that *buen vivir* constitutes an extraordinarily inclusive vision for positive mental health.

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[7] *Buen vivir* is the Spanish term. Other terms in indigenous languages include *suma qamaña* (Aymara) and *sumac kawsay* (Quechua).

Conclusion

This chapter has reviewed some of the important recent developments in positive approaches to mental health, happiness, and wellbeing. While we generally welcome the positive emphasis and recognition of people as active agents within their own lives, we also sound some notes of caution. In particular, we are concerned by the dominance of quantitative assessment in this area, which seems ironic given its overwhelming emphasis on subjective perspectives and the *quality* of life. The limitations of quantitative approaches are particularly clear when they are used in societies other than those in which they were designed, since they inevitably reproduce their own categories, and are unable to recognise understandings of the world that are different to their own. Researchers in non-metropolitan contexts and at the more critical end of the mental health/psychosocial wellbeing paradigm, in particular, question the separation of psychological from social, and indeed of the psychological from the relational and material. Advancing positive mental health requires that we restore these connections and rebalance our research agendas so that the complexity of subjectivity and lives lived with others becomes the centre, rather than the periphery, of our vision.

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8

Global Mental Health and Psychopharmacology in Precarious Ecologies: Anthropological Considerations for Engagement and Efficacy

Janis H. Jenkins and Ellen Kozelka

Public health campaigns for mental health promote declarations such as "Defeat Depression, Spread Happiness" in India, "Chains Free" in Indonesia, "Silence Is Not Health" in Argentina, or "A Flaw in Chemistry, not Character" in the United States. Within Global Mental Health (GMH), the proclamation of "No health without mental health" (WHO 2005) serves as a rallying point for providers, researchers, and advocacy groups. Calls to "scale up" mental health services in countries designated as low- and middle-income countries (LMICs) have been given priority (Patel et al. 2007; Patel et al. 2009; de Jesus et al. 2009; Eaton et al. 2011). Proponents argue that as matters of urgent need and human rights, there must be greater access to evidence-based treatments, typically with reference to psychopharmaceuticals and psychosocial interventions (Patel 2014). Often only the former is offered, but only the latter is understood to require much adaptation as a matter of cultural validity. While in this chapter we pay particular attention to psychopharmaceuticals, we argue that both types of treatment (and more) require particular cultural consideration of patients and families (Good 2010; Jenkins 2015a; Whyte 1991). The "more" that we have in mind entails stepping beyond the confines of what currently counts as "evidence based" treatment to also take into account both structural and ecological constraints (Farmer 2004; Metzl and Hansen 2014; Jain and Jadhav 2009). Broadening the scope of GMH holds

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"enormous potential to contribute to [these] challenges by exploring cultural feasibility and acceptability of interventions, understanding the impact of health services on the daily lives of providers and patients, and uncovering institutional processes that lead to inadequate and disproportionate commitment to mental health" (Kohrt et al. 2015, p. 341). In this chapter, we identify specific problems with respect to illness experience, cultural interpretation, and local provision of care in relation to psychopharmaceuticals. Further, we suggest strategies to address these difficulties across diverse settings.

Cultural and Political Ecologies of Persons, Families, and Psychotropics

The widespread dispensing of psychotropic medications is typically practised with the idea that these drugs, as bioactive compounds, do not require cultural consideration. Closer inspection shows that this is definitely not the case (Jenkins 2010; Ecks 2013; Ecks and Basu 2009; Basu 2014). First, there can be no doubt that psychopharmaceutical treatment concerns subjective experience and cultural interpretation of illness and healing. This necessitates treatment practices that are guided by a contemporary understanding of culture. What is therefore required is an appreciation of culture in non-reductive terms (Martínez 2000; Jenkins and Barrett 2004; Biehl et al. 2007; Parish 2008). Culture is not a factor, but rather a pervasive process at work in nearly every aspect of mental health and illness, including psychopharmaceuticals. As there are many definitions of culture, it is useful to provide our theoretical formulation of culture with attention to lived experience:

> Culture is not a place or a people, not a fixed and coherent set of values, beliefs, or behaviors, but an orientation to being-in-the-world that is dynamically created and re-created in the process of social interaction and historical context. Culture has more to do with human processes of attention, perception, and meaning that shape personal and public spheres in a taken for granted manner. What do we pay attention to and how? What matters, and what does not? (Jenkins 2015a, p. 9)

This approach takes as fundamental the inevitability of multiple, competing perspectives (vs. one-sided accounts of "clinical facts" or "noncompliant patients," for example). Attention to the multiplicity of perspectives leads to an appreciation of the reality that the experience of giving and taking medication is neither straightforward nor unilateral.

Second, anthropological attention to gender, class, and ethnicity is clearly integral to interpreting these perspectives. For example, appreciating gendered differences in a specific cultural environment is key for communicative clarity in healthcare encounters, as well as aetiology. Worldwide, women and girls disproportionately struggle daily against affronts to psychic integrity that may be conducive of serious conditions such as depression, trauma, and psychosis (Jenkins and DelVecchio Good 2014). These may also alter women's ability to seek treatment. Likewise, class and socio-economic status are widely recognized as a social determinant of mental health status (WHO 2014). Ethnicity among low-income minorities in countries with vast economic inequality (such as in the United States or China, for example) is marked by a "greater exposure to racism and discrimination, violence, and poverty, all of which take a toll on mental health. Living in poverty has the most measurable impact on rates of mental illness. People in the lowest stratum of income, education, and occupation are about two to three times more likely than those in the highest stratum to have a mental disorder" (U.S. Surgeon General 2001; also discussed in Institute of Medicine 2013; Kleinman 1986; How et al. 2011). Understanding the toll that ethnicity and socioeconomic condition, like gender, take on persons' capability to act, and designing GMH interventions with them in mind, will allow researchers and healthcare workers to provide treatment that persons have the power and desire to access.

Third, in-depth empirical attention to the perspectives of persons and families living with mental illness is a surprisingly neglected area of research (Jenkins and Karno 1992; Hinton et al. 2015); but, available ethnographic accounts show that these persons and their families are grappling with distressing conditions and the complexity of taking medications. They do so, by and large, with little clinical or social support. In both low- and high-resource settings, the taking of psychotropic drugs invariably entails considerable cultural conflict, social stigma, and paradox for persons and their families (Whyte et al. 2002; Jain and Jadhav 2009; Jenkins and Carpenter-Song 2005, 2008; Dumit 2012; Read 2012). Analytical attention to how these cultural forces impact the course and outcome of treatment will be critical to formulating successful GMH interventions.

Finally, patient-provider relationships are often culturally defined by power and embedded in hierarchical social relations of difference. Properly understood, prescribing and taking medication is as a collaborative undertaking that requires negotiation and renegotiation over time. Though not often practised, there are fruitful models to draw upon, such as those pioneered by Partners in Health (Farmer 2015; PIH.org) and the international Hearing Voices Movement (Woods et al. 2013); maximal healthcare efficacy in terms of psychopharmaceuticals requires maximal collaborative partnership. Yet, in terms of serious mental illness, GMH has little to show that would constitute the fruits of such a collaborative approach. Many GMH care providers and others believe that serious mental illness necessitates the use of psychotropics, and we do not dispute this claim. Yet, for psychopharmacological treatments to remain both valid and efficacious on a global scale, providers must work to transcend the notion that the primary "problem" is patient "compliance" or "adherence." This simplistic view of a patient's relationship with their medication fails to take into account their subjective illness experience, their interpretation of the problem, as well as their own agency and desired outcomes. When "compliance" and "adherence" are the starting points (and often the endpoints) in clinical thinking, it should be little wonder that they are also often the stopping point for patients in resource-poor and affluent settings alike. Without discounting the importance of adherence to psychopharmaceutical regimens, the giving and taking of medication would more productively be conceived as a collaborative process of engagement that only occurs as part of a cooperative effort based on engaged listening.

Thus, our research experience suggests that treatment via psychopharmaceuticals must be approached through a fine-tuned engagement that seeks to take into account (1) the social, cultural, and psychological contexts of mental illness and its treatment, and (2) the ecological features of environments with respect to socioeconomic and political conditions that may predispose persons to mental illness through entrapment in precarious situations. Our argument is that GMH must proceed with an understanding of these dual sets of intersecting factors bound together "extraordinary conditions" of affliction and precarity (Jenkins 2015a). We intend these observations to be a critical locus for making meaningful differences for the course and outcome of mental illnesses worldwide.

The Globalization of Psychopharmaceuticals

The global circulation of the now familiar biomedical narrative of psychotropic drugs as chemical compounds with biological effects has produced widespread cultural knowledge of psychopharmaceuticals and ideas of their efficacy. The extent of this circulation and its particular meaning to patients and families in a given location at a given time, however, should not be presumed to always be straightforward, obvious, or even shared cultural knowledge. While global awareness of the existence and potential utility of psychotropic medications has increased cross-continentally, availability and access can be limited or precluded altogether. While it is obvious that economic and political restrictions represent the first line of separation in determining who receives care, there are other obstacles in relation to mental health policy at international and national levels. Addressing them necessitates consideration of the cultural dynamics of power, access, and privilege.

One significant obstacle is the prevailing presumption that it is inevitable and expected that scarcity of resources impedes access to treatment. Indeed, many clinical sites lack access to even relatively inexpensive WHO-dubbed "essential medicines," let alone more costly psychopharmaceuticals. Kim et al. (2013) have critiqued healthcare policies that take for granted the inevitability of scarcity of resources, particularly in low-income countries. However, even in settings where consistent access to medication exists, the high frequency of discontinuation of medication is noted in both high- and low-income countries (Jenkins 2015a; Lieberman et al. 2005; Read 2012). For example, in the United States, the CATIE study found a 75% discontinuation rate (Lieberman et al. 2005). That study failed to collect empirical data that could account for this finding. Survey data in Ghana reported that in a sample of 1290 patients, 80% stopped taking their medication (Mensah and Yeboah 2003). Reasons for cessation of pharmaceutical regimens frequently involved practical problems of logistics and resources. Yet beyond economic resources to provide concrete forms of treatment, there is a need for greater support from healthcare workers to provide drug information and empathic listening about the shortcomings and difficulties patients and families experience (Brown et al. 1986). Ethnographic research has demonstrated that those afflicted with mental illness and their kin are far from unfamiliar with, or reluctant regarding psychotropic drugs; indeed, they are often aware and highly motivated to seek out such treatments (Basu 2014; Ecks 2013; Duncan 2012; Read 2012; Whyte 1991; Jenkins and Carpenter-Song 2005). In Ghana, for example, not only are people aware of "hospital medicine" (psychopharmaceuticals), they also resort to it frequently, often before seeing a religious healer (Read 2012, p. 441). If the social, cultural, and economic realities of patients with serious mental illness are not given adequate attention, the wellbeing of afflicted individuals and families can neither be understood nor be managed efficaciously with only psychotropics. At this juncture, the locus of failure lies primarily with those of us researching, designing, planning, and clinically implementing mental health programmes around the world. More must be done to ensure that the implementation of the GMH scale-up is done with a fine-tuned engagement towards the culturally, temporally, and geographically dynamic relationships of treatment and contexts of healing.

"Scaling Up": Problems Spurious and Genuine

Within the field of GMH, there have occasionally been rather startling claims that the overall undertaking is not only fraught but also impossible, since psychiatry really has no effective treatments or culturally valid services to offer (Summerfield 2012). Those who propose this remarkably nihilistic critique of GMH interventions as summarily useless do not appear to have carefully considered the affect that such a claim, if taken seriously, would have on the lives of persons living with serious mental illness and their families. This view appears in part to be an attempt to critique the "Western" biomedical hegemony of GMH and a plea to attend to local and indigenous healing modalities. Such a point is well taken; local understandings of illness and disease most certainly affect the subjective experiences of serious mental illness as well as their course and outcome. However, the presumption that indigenous forms of healing are unconditionally likely to be Rousseauian "natural" wellsprings of resilience requires ethnographic evidence based on patient and family experience in lieu of apparently romantic or naive zeal that the "West" has it all wrong and "The Rest" (must) wistfully have it all right (or at least not that bad). In fact, this view discounts how local social and cultural conceptions of disease may negatively affect course and outcome, that is, social stigma (Jenkins and Carpenter-Song 2005, 2008; Read 2012). Ironically, such critiques of GMH take cultural relativism farther than most contemporary psychiatric anthropologists, in effect using it as a justification to oppose all psychiatric treatment and intervention.

There is a critical need for a deep understanding of the mutual entanglement of culture and psyche in psychiatric care, especially in light of the significant social stigma that mental illness nearly always entails. This requires careful attention to subjective experience and cultural validity of psychiatric nosology and treatment (Kleinman 1988). In fact, the cultural adaptation of interventions is something that anthropologists have argued for since the 1980s, and, thus, does not appear novel. As we have noted, a working understanding of the resonance of psychotropics in a given culture must be grounded in the particular concerns of persons actually living with mental illness (Jenkins 1991, 2015b).

If the validity of psychiatric treatment and intervention with cultural adaptation is accounted for, determining the intended recipients of the scale-up represents another problem for GMH researchers, care providers and advocates. The scale-up aims to make treatment and care for serious mental illness more readily available to those who do not have access; thus, we have reservations with respect to categorizations of those "most" in need based solely on a country's designation as low or high income. As described in previous sections, consideration of individual and cultural influences to care for serious mental illness cannot be delimited to LMICs or indigenous peoples living in high-income countries (HICs). All persons exist enmeshed in a sociocultural, political, and economic milieu and this gradient of power greatly affects the dynamics of health and recovery. We believe that it is far too early in the nascent field of GMH to become sedimented in taken-for-granted assumptions and expectations about how to approach relevant fields of application. Patel (2014) draws attention to the well-known problem of the boundaries between the knowledge and practices of "developed" and "developing countries", pointing to the need for reciprocal and collaborative learning that can address improved mental health worldwide. While this is clear, it has yet to be recognized that such distinctions apply also to the problematic designation of "high-income" countries opposed to "low- and middle-income countries." GMH must fully recognize and emphasize the reality that such designations appear to subscribe and to succumb to the necessary and justifiable requirement of "scarcity" of attention and resources—so astutely critiqued by Kim et al. (2013)—as justification for triaging in some places (India, sub-Saharan African) and not others. While the reality that there are many settings that require urgent care is daunting, these cannot adequately be identified through current reductive designations of developing or LMICs.

Thus, we challenge the ideas that (1) LMICs and HICs should receive different attention to mental health—all those suffering should have the ability to participate in the healing process with their families and mental health-care providers—and that (2) psychopharmaceutical medications and psychosocial services should be ranked hierarchically, with psychopharmaceuticals eliminating the necessity of psychosocial services. There is a critical need for a spectrum of mental health services in both LMICs and HICs. We object strongly to practices of treatment for serious mental illness based primarily (if not exclusively) on psychopharmaceuticals. The scale-up of GMH services including psychopharmaceutical treatments should be paralleled with an equal scale-up of culturally meaningful psychosocial services, because both are necessary aspects to contribute to the conversation on cure and healing for serious mental illness. Both psychopharmaceuticals and psychosocial services contribute to the wellbeing of the individual with serious mental illness, their subjective experience of social functioning, and their family's understanding of social functioning. As we shall see in the next sections, what social functioning means varies across space and through time; but, nonetheless, the concerns patients and families put forward are fundamentally about economic and social subsistence. Here, we again challenge the assumption of inherent global difference, based on socioeconomic status. Through our research and the review of others, we have seen that what patients and families want, be they middle-class US residents, working-class immigrants to the UK, subsistence farmers in Ghana, or political and environmental refugees in Indonesia, resonates with each other. They all want, in their own social, cultural, and economic way (or their kin want them) to function. The global resonance of social functioning brought us to our argument on the fundamental need for attention to subjective experience. It provides us with a window into understanding how social, cultural, and economic differences affect treatment.

Matters of Immediacy: Subjective Experience of Psychopharmacology in Precarious Ecologies

The effectiveness of GMH interventions is contingent on close attention to the complexities of daily experience and the substantial suffering among those who seek treatment for serious mental illness via psychotropic medications. The process of taking psychotropic medication can be bittersweet, since subjective experience can incorporate both treasured relief and troubling social preoccupations, that is, stigma. In the absence of being involved with supportive groups to interpret and to develop strategies to manage these experiences, and in the absence of provider disclosure of the limitations and serious metabolic side effects associated with medications prescribed for serious mental illness, all does not typically go well. In our research experience (with Mexican American, Euro-American, African American, and Native American populations), nothing short of a "cure" is expected and longed for (Jenkins and Carpenter-Song 2005; Jenkins 2015a).

Understanding subjective experience can give incredible insight into why patients decide to take or not take their medication. One of the authors worked with patients of diverse ethnic and socioeconomic backgrounds in the United States using atypical antipsychotics to understand the subjective experience and meaning of treatment for schizophrenia and related mental illnesses. By analysing their subjective experience through narratives, she found that cultural conundrums of "stigma despite recovery" were extremely common, and greatly affected not only their perceptions of treatment, but also their expectations for recovery and healing, in other words their clinical and social outcome (Jenkins and Carpenter-Song 2005). They often reported experiencing long-term treatment with antipsychotics as paradoxical, both medically and socially, by saying things like: "I feel better but not cured" or "I can sleep, but can't work." Others even reported having to make the choice between being "fat" (drooling or sexually diminished) or being "crazy" (Jenkins and Carpenter-Song 2005). In the context of the United States, where economic independence is paramount to social success, it makes sense that without proper counselling, discussions about treatment, and support groups to manage these conundrums, patients would begin to make choices to improve their social condition, even if that is in detriment of their biomedical condition. In these cases, improving their social condition often meant ceasing their adherence to psychopharmacological regimens. By understanding a person's subjective experience of their illness and society's conception of their condition, we can see just how influential culture can be on course and outcome.

Surprisingly, culture's influence upon the social circumstances surrounding treatment is remarkably similar for patients and families in both HICs and LMICs. Though the dynamic interplay of temporal and geographical factors on culture may result in different understandings of serious mental illness, how it affects the afflicted, and the appropriate course of their treatment, recovery of social functioning remains the ultimate goal. Ursula Read observes that

> [c]ampaigns to scale up mental health services in low-income countries emphasize the need to improve access to psychotropic medication as part of effective treatment, yet there is little acknowledgement of the limitations of psychotropic drugs as perceived by those who use them … whilst medication undeniably brings benefits for many with severe mental illness, such campaigns seem to have glossed over the limitations of psychotropic drugs, particularly antipsychotics, and the ambivalent attitudes they provoke in those who take them. In many cases antipsychotic treatment had been discontinued, even where it had been recognized to have beneficial effects. The failure of antipsychotics to achieve a permanent cure also cast doubt on their efficacy. (2012, pp. 438–439)

As the title of Read's (2012) article poignantly conveys, Ghanaians "want the [psychopharmaceutical] that heals me completely so [the major mental illness] won't come back again." In an earlier study in Ghana, some hospital patients who reported stopping psychotropic medication had sought treatment from a spiritual healer (Mensah and Yeboah 2003). Using an ethnographic methodology, anthropologist Ursula Read (2012) later obtained additional data on the reasons for discontinuation. These included fatigue, drowsiness, weakness, and side effects such as movement disorders and stiffness (Read 2012, p. 439). For many, dissatisfaction with psychopharmaceuticals was rooted in the perception of limited or short-term efficacy and unpleasant side effects.

"While reluctance to take antipsychotics is often attributed to psychopathology or lack of 'insight' … the subjective experience of unpleasant and dangerous side effects" has "a significant impact on patients' willingness to take them" (Read 2012, p. 439). In Ghana, the short-term benefits (reduction of symptoms) are highly valued; however, they are not enough. For the patients and families Read worked with, a return to social functioning is more valued than symptom reduction. Furthermore, the side effects of antipsychotics conflict with cultural notions of health that emphasize the value of strength (Read 2012, pp. 445–447). In sum, taking medication and feeling better is a complex, nuanced cultural matter.

Similar critiques of care for major mental illnesses, resonate in both HICs and LMICs. This reveals not necessarily that the same solution may be applied globally, but that the same deficiencies of care exist globally in situations of socioeconomic and political precarity, all of which deserve research and clinical attention. So, then, use of psychopharmaceutical treatment is not defined solely by access or awareness. Like their counterparts in the United States, faced with the dilemma of being "fat" or "crazy" Ghanaians must choose between being "noncontributing" or "crazy" (Read 2012). Some persons, when faced with such an impossible cultural choice, in the absence of clinical appreciation and engagement with such difficulties, simply give up, or in biomedical terms, become noncompliant.

Experience-near perspectives must inform critical analyses of psychotropic use in order to demonstrate the numerous quandaries involved in understanding the indeterminate cultural, social, and biological effects of psychotropic drugs (Jenkins 2010). A reduction of psychotic symptoms does not necessarily entail a return to "normal," especially when considering the side effects and chronic nature of treatment. "Since health is aligned with strength, healing is signified by a return to productivity" (Read 2012, p. 447). Thus, when treatment, aimed at health of the individual, interferes with social obligations, the treatment can no longer be considered efficacious. Efficacy gives a drug its value, but that efficacy is social and culturally defined. In Ghana, we see the social lives of medicines (Whyte et al. 2002) at work in both the initial acceptance and later rejection of psychopharmaceuticals. While antipsychotics are highly valued for their sedative nature, after some time, many find the medication "too strong." In part, this may be because mental healthcare workers tend to use high doses, related with the perception of the comparative severity of psychosis in Ghana (Read 2012, pp. 444–445). Yet, this increases the likelihood of side effects, a negative patient reaction and noncompliance. In this case, "noncompliance" reveals the patient's expression of rationality as compared to the mental healthcare workers' (Van der Geest et al. 1996, pp. 165–166). In some cases and in some places, reduction of symptoms may be enough to continue on the path to recovery. But, the inherent value of symptom reduction through psychopharmaceuticals is in the ability to return to social functioning. When these drugs produce side effects that further decrease the person's ability to participate in society, it is understandable why patients and their families would decide that the best decision would be to stop taking them.

The need for cultural consideration of psychopharmaceuticals extends beyond analytical attention to clinical implementation. Psychosocial and psychopharmaceutical treatments, as a necessarily dual process, need to be explained as both open-ended and unknown in respect to their effects over time. We believe that a fine-tuned engagement with patients and their families is necessary for implementing GMH interventions to prevent the abuse of or improper implementation of the scaling up of GMH. Engaged listening and talking provide critical therapy even though there is the cultural conception in many societies that this form of therapy cannot or does not have the same efficacy as psychopharmaceuticals. The expectation for immediate and sustained cure is unlikely to be met in the case of serious and persistent mental illness. Nevertheless, expectation for incremental improvement over time can be understood as integral to the healing process. Thus, when Akosua, a Ghanaian patient on antipsychotics, says, "I want the [pill] that will heal me completely so it won't come back again" (Read 2012, p. 447), we can understand what type of cure she is looking for, which is linked to her sociocultural conceptions of health. In this case, the collaboratively based "engaged listening" and conversation would allow mental healthcare providers to begin the conversation on the open-endedness of current treatments for serious and persistent mental illness. By more accurately representing the timeframe of treatment as uncertain and open-ended, this may help address issues of pharmaceutical adherence and continuation of care.

Further, the evaluation of GMH interventions must be conducted with a fine-tuned engagement to culture. When prescribing antipsychotics, mental health workers need to engage in dialogue with the persons seeking treatment. We concur with Read (2012) that mental health workers need to be frank about the limits of antipsychotics; they must discuss openly the true medical and social expectations that can be and often are associated with the use of psychopharmaceuticals. Evaluation of interventions must ensure that these conversations are occurring and patients and families are receiving the support they need psychopharmacologically, socially, politically, and economically. In other words, the "scaling up of psychiatry in low-income countries" should be carefully monitored, lest it actually become a scaling down to "administrative psychiatry whose primary objective is the prescription of psychotropic drugs and the reduction of symptoms, rather than addressing the social or psychological factors which may contribute to mental breakdown and recovery" (Read 2012, p. 441). The aim of the scale-up of psychiatric services should be to ensure the best possible treatment for mental illness; then, projects to implement that care must provide not just an initial investment but ongoing training, monitoring, and accountability. This includes both medicinal treatment and psychosocial treatment. In this way, patients and their families can better understand their condition, what current treatment can actually provide, and how they all can participate in the healing process. In the next section, we will explore how this treatment extends far beyond prescribing psychotropic drugs and into the arenas of social, economic, and political reform.

Advocating for Recovery: Development and Delivery of Care

Anthropologically, it is clear that the complex psychocultural and sociopolitical dimensions of the subjective experience of medication and treatment continue to require close attention. There is a crucial need for engaged listening to the fears, hopes, and lamentations over cures that are only partial or ephemeral. The delivery of healthcare is one of the primary aspects of patient experience of psychotropic medication that must be considered; it can and does have a foundational influence on how patients experience their medication. This has a drastic impact not only on their subjective experience but also on course, outcome, and compliance. Here we will illustrate the need for both an individual and collective understanding of the treatment environment and how open dialogue is the best method to achieve this at the patient-provider exchange.

For example, post-traumatic stress disorder (PTSD) has always been a source of controversy. As Good et al. (2014, p. 5) argue, there is good reason to investigate and critique the emergence as well as the expansion of PTSD as a clinical category. In anthropological literature, this critique has often been directed at the standardization or "professionalization of social suffering" (Kleinman and Kleinman 1997; Breslau 2004) but it has also addressed the rhetoric of "humanitarian interventions" which use diagnoses of trauma as vehicles for alternative modes of sovereignty to further political ends (Good et al. 2014, p. 5; Kienzler and Pedersen 2012). Jenkins (1991) further argues that overuse of medical categories like PTSD can lead to a neglect of the social and political roots of the causes of PTSD. Thus, there are indeed problems, both spurious and genuine, to the expansion of PTSD as a category and the worldwide increase in diagnosis. However, that does not make the suffering currently clustered under the diagnostic category PTSD any less real. What these scholars criticize or challenge, we argue, is not that suffering can be caused by particular events, or even series of events, but that some physicians and social policy makers can become slaves to the diagnostic criteria, using statistics generated from them to further political or economic goals completely divorced from the suffering each criterion and its number represents. Jenkins (1991) has argued for the opening up of the category PTSD. Thus a legitimate critique of PTSD is focused not on whether or not the illness exists, but how others, particularly aid workers, GMH interventionists and researchers who may not be based in or particularly familiar with the country in question, respond to it and impact the healing process. These arguments echo our call for the effects of environment on mental health to be taken seriously.

This is not to deny that some scholars discount PTSD as a legitimate diagnosis. Some have referred to it as a pseudo-condition that both pathologizes entire populations and represents a new form of colonialism (Summerfield 2004; Pupavac 2002). However, this narrow view does not follow from the justifiable critiques offered by others (Kleinman and Kleinman 1997; Jenkins 1991; Breslau 2004; Good et al. 2014). Referring to PTSD as a pseudo-condition could be what Read (2012) described as a miscommunication; yet the GMH interventions that would result from this critique would have a significant impact on what kind of care would be made available and what would not, because it neglects to take into account the larger socioeconomic and political influences on serious mental illness. Further, this argument's foundational claim that psychotropics are unwillingly pushed on "non-Western" populations is a direct contradiction to what Read discovered in Ghana or Good et al. (2014) discovered in Indonesia, both major recipients of international aid. There are certainly serious issues with the way interventions using psychopharmacology are implemented in Ghana and other places, but this is not because the illness of psychosis is not "real" or not socially recognized. It is because there has been structural and individual miscommunication between providers and the patients and families seeking treatment.

So what are we debating in terms of major mental illness? Is PTSD or any diagnostic tool really good enough to discuss serious mental illnesses as categories? If symptom clusters are found around the globe, then is the real debate here epistemological? This we argue can be addressed in terms of the methods used for scaling up GMH. We and many other anthropologically oriented GMH researchers argue for mixed methods in interventions, evaluations and education. For example, Good et al. (2014) collaborative efforts with the International Organization for Migration (IOM) in Indonesia entailed the development of mental health outreach teams, which was staffed by Acehnese general practitioners and nurses (Good et al. 2014). The Harvard Team's role in the project was not intervention but evaluation. Their supporting role as researchers listening seriously to the conditions of the Indonesian people in tandem with their Indonesian colleagues allowed them to help advocate for the care people asked for. Thus, fine-tuned engagement towards the cultural manifestations of trauma and suffering and collaborative approach to researching, implementing, and evaluating allowed the national and international team tasked with responding to Indonesia's crisis to begin responding to the mental health needs of the Acehnese people and advocate for the political, economic, and social issues to be factored into it.

Culture, psyche, and biology are all integral to understanding the complex processes and pathologies of mental illness. The biological aspects of an illness cannot be understood and thus treated properly if the larger socioeconomic and political environment as well as individual, subjective experiences are not equally considered. Like the moving parts of a conversation, attention and awareness must be given to all three, if not more. We recognize that different researchers in different fields will focus in on or find certain parts of that conversation more interesting. Psychiatrists may be more interested in the changing levels of serotonin while a patient is on SSRIs, while psychiatric anthropologists may be more interested in learning about the embodied experience of consuming the SSRIs. While extremely different in focus, when combined, they provide a clearer picture, overall, of what psychotropics do, how they are experienced, and what factors influence persons to take or not to take psychopharmaceuticals. The embodiment of culture through the use of psychotropics, has been a focus of this paper, but it is but one of the many moving parts that enter into the conversation on GMH. Here, we have argued that open dialogue and interdisciplinary work via a fine-tuned engagement with the cultural context should be the foundation of GMH interventions and evaluation.

Conclusion

This chapter has primarily discussed the problems of efficacy and validity associated with mental health services in relations to pharmacological treatments for serious mental illness. We have argued that services require cultural validity contingent on the specific environment of the planned intervention.

In order to create both valid and efficacious interventions, GMH researchers, practitioners, and advocates must recognize that (1) psychopharmacological attention and treatment can be successful only when treated in equal tandem with the psychosocial interventions; (2) patient and family illness experience, interpretation of the problem, and desired outcomes must be understood; (3) local provision of care must be collaborative, which in the case of psychopharmacology requires attention to the first two points that we have argued as matters of engaged listening; (4) what "functional" means varies globally and temporally, but it drastically impacts the understandings of our second point, and thus they must be taken into consideration when formulating an intervention; (5) the meaning of treatment and healing modalities entail subjectively experienced paradoxes of taking medications that can only be understood when persons living with mental illness are engaged in the provision of services through collaborative listening by those providing them. Thus, there are many moving and intertwined parts involved in the conversations surrounding the scaling-up of GMH interventions. A critical first step in this direction is engaged listening, collaboration, and an informed understanding of the particular circumstances of the environment in which particular interventions are directed. We have argued that to be effective, GMH must proceed with an understanding of these sets of intersecting factors as "extraordinary conditions" (Jenkins 2015a). We are convinced that attention to this critical locus is necessary to make meaningful differences for the course and outcome of mental illnesses worldwide.

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9

Commentary on 'Mental Health Across the Globe: Conceptual Perspectives from Social Science and the Humanities' Section

Duncan Pedersen

This part of the handbook deals with transdisciplinary perspectives from the social sciences and humanities on some of the most crucial issues of the Global Mental Health (GMH) agenda. The various chapters take us on a captivating disciplinary tour across central GMH notions such as medicalization of distress, recovery from severe mental illness, space and mental disorders, culture and treatment outcomes, positive mental health and happiness, cultural idioms of distress and psychiatric classifications.

Miller (chapter 5) tackles issues of colonial and postcolonial psychiatry in the context of Africa and postcolonial India; Aldersey and collaborators examine the notion of 'recovery' from severe mental illness, using a comparative perspective in three different cultural contexts: the USA, New Zealand and Nigeria; McGeachan and Philo (chapter 2) posit a geographically informed analysis of mental health and illness and its spatial distribution, examining a wide range of concepts going from spatial epidemiology to therapeutic landscapes. Harding (chapter 4) contributes from a historical perspective to explain how modern concepts of mental health and illness are constructed in Japan and India, through a dialogue among ancient healing traditions and the legacy of colonial and postcolonial systems of mental health care in successive encounters with the West. Jenkins and Koselka (chapter 8) show us, from an ethnographic perspective, how persons and families living with mental illness are confronted with hard decisions when taking psychotropic drugs, and

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remind us to acknowledge the impact of culture in the course and outcome of treatment as crucial to formulating successful GMH interventions. White and Eyber (chapter 7) contribute to this section with a critical analysis of the key concepts of subjective and psychological well-being, including the discussion of happiness, as highly relevant notions to GMH. Finally, Thornton (chapter 3) adopts a philosophical perspective in focusing on the relations between cultural idioms of distress and the DSM-5 taxonomy of mental illness.

Under the title 'Reflecting on the medicalization of distress', Miller (chapter 5) attempts to explore the

> post-developmental critique of the dominant ideology within the Movement for Global Mental Health (MGMH) by locating what may seem to be primarily clinical debates within wider arguments about the validity of development theory.

The introduction points at some of the well-known criticisms against the Movement for Global Mental Health (MGMH) and its goals, and more specifically the inevitable medicalization of distress that the interventions proposed by the MGMH may lead to, under the false assumption that the Western model of development can be easily transferred or replicated across the globe, irrespective of the cultural, societal and geographical contexts (Fernando 2014; Summerfield 2012; Watters 2011; Kirmayer 2002). The section titled 'Changing models' tackles the concepts of 'culture' as defined by Kuper (1999) and 'idioms of distress' (Nichter 1981), such as '*koro*' (Yap 1965) and *ataque de nervios* (Oquendo 1995). In the section titled 'Historical Consciousness', issues of colonial and postcolonial psychiatry are discussed in the context of Africa and postcolonial India.

The literature review is somewhat helpful to track back the arguments for and against the medicalization of distress, as well as the emergence of cultural categories such as 'idioms of distress', a construct developed by anthropologists in the early 1980s. However, the concepts and examples are scattered across countries and cultures along five decades of recent history and remain to some extent disconnected from the main argument.

Since its first introduction to the academic discourse, 'idioms of distress' has turned into a self-explanatory term that is used to make sense of cultural categories as diverse as *ataque de nervios* (Guarnaccia et al. 2003), *susto* (Weller et al. 2002), *espanto* (Tousignant 1979), *ihahamuka* (Hagengimana and Hinton 2009), *llaki* and *ñakary* (Pedersen et al. 2010) and *neurasthenia* (Ware and Kleinman 1992), among many others. These 'idioms' are considered polysemic and idiosyncratic phenomena used to communicate a wide range of personal and social concerns that may or may not be related to individual distress or mental disorder. Thus, physiological and psychological expressions of distress are not simple manifestations of a subjacent biological reality but also metaphors that reflect and represent a variety of meanings that serve many social and psychological purposes (Browner and Sargent 2007). In summary, idioms of distress may reflect past exposure to violence and trauma, but also present challenges and foreshadowed troubles. Yet, they are not mere reflections but influence and are in turn influenced by social relations and, thus, constantly transformed, recreated and invested with new meanings and attributions (Pedersen et al. 2010).

Miller continues his analysis to conclude that post-developmental theory has to some extent reinforced the critique of the dominant, biomedical model within the MGMH and calls for a healthy scepticism towards the medicalization of distress, where a false opposition may present 'a cultural preservationist defense of local systems of distress and healing' as the only valid alternative to psychiatric neocolonialism.

Aldersey, Adeponle and Whitley (chapter 6) examine the notion of 'recovery' as a polysemic term emerging in the early 1990s, which has a plurality of meanings. Today, the term 'recovery' evokes different understandings, which may loom large if we compare the understandings of this term from a service user perspective with that of a Western-trained psychiatrist and even that of a general practitioner. It becomes evident in the analysis made by Aldersey et al. that each one holds different meanings and has dissimilar expectations with regard to 'recovery'. These differences are even more accentuated if we compare the notion of recovery from the official discourses coming from countries in different stages of income and social development levels.

The central argument of the chapter by Aldersley and colleagues is organized around case studies from three different countries: the USA, New Zealand and Nigeria. Distinguishing between different conceptions of recovery among these countries, it clearly illustrates that their respective knowledge about recovery from severe mental illness is not necessarily connected with their actions regarding the management of mental illness and the interventions leading to an independent and autonomous life, supported employment and peer support, and—more importantly—to improved mental health outcomes (including the total or partial remission of symptoms).

In the USA, the notions of recovery are wide-ranging. The emphasis on recovery from mental illness is much influenced by the prevailing value system: the overriding notion to live 'an autonomous, productive and meaningful life' is in line with the values of rugged individualism and the productive citizen predominant in the USA (Myers 2010). In the New Zealand case, recovery is strongly induced by an underlying egalitarian and community-based philosophy, with a heavy influence of Maori culture and service users' collective values and perspectives, in contrast with the individualistic approaches to recovery, which are typically exhibited in the USA and other countries of the Global North.

Nigeria represents the poorest and least developed of the three countries under examination, and features a mental health service delivery system with public community-based general hospitals, stand-alone psychiatric hospitals and a few private beds. In this country, the mental health care system was established under the Lunacy Act (1916) dating back to the colonial period. Today, many changes have been introduced following the 1991 National Mental Health Policy, which aims to cover all levels of care and promotes the integration of mental health services into primary health care (PHC). However, not all proposed changes have been operationalized, and to date 'recovery' remains a concept with no direct translation into action programmes.

According to the widely known World Health Organization (WHO) Collaborative Study (Sartorius et al. 1986) on schizophrenia and prognosis in ten countries, Nigeria compares favourably with other more developed and industrialized countries. The Nigerian case raises many questions regarding the explanation for better social and functional outcomes in severe mental illness as compared to more advanced countries. Positive family involvement and related contextual factors (i.e., peer support), appear to explain, at least in part, the better outcomes and prognosis of severe mental illness in Nigeria, despite a weak and poorly organized mental health system. The three case studies presented here by Aldersey et al. provide a useful matrix for analysing the recovery construct and its legitimacy in three different cultural contexts. Despite the obvious differences among the three countries, there is a common thread in the notion of recovery across countries and cultures, which includes the provision of humane, empowering and holistic mental health services.

However, the comparative analysis of the three cases does not include a discussion on the degree of westernization currently prevailing in the service delivery network in each country. While the USA represents a top-down approach of the concept of recovery, much imbued by a Western value system, the New Zealand case represents the bottom-up approach, involving the Maori culture and its own notions of healing and coping with and recovery from mental illness, in parallel coexistence with Western psychiatric practices. Finally, the Nigerian case represents more of a hybrid, where Western psychiatry coexists with traditional and religious healing practices, and the notions of recovery are culture-specific and not necessarily influenced by the Western value system. Pat Bracken and other 'critical' psychiatrists in the UK have argued for a greater inclusion of people with mental illness into innovative alternative approaches to mental health care—also called 'user/survivor-led approaches'—more responsive to their needs and illness experience and steering away from biomedical approaches to recovery. Building on a critical perspective on the MGMH, these authors emphasize two categories of alternative approaches to the Western dominant model of recovery: non-Western approaches, mostly developed by other cultures and contexts to deal with persons with mental illness, and non-medical approaches, developed in Western settings by those who have not been helped by psychiatry (Bracken et al. 2014). They acknowledge the importance of preserving these alternative community-based approaches to mental health care, which in many ways may be equally or more effective in leading to recovery from severe mental disorders than the conventional Western-based mental health care models currently being used in high-income countries.

McGeachan and Philo (chapter 2) present us with a rich geographically informed analysis of mental health and its spatial distribution, which is highly relevant to current and future debates within GMH. Their analysis leads us to look at the individual living in a material space, never geographically static but continuously dynamic, cross-cutting into a range of not only material but also social and symbolic worlds, which in turn manifest at different scales. The 'local' and the 'global', to which now we may add the 'planetary', are some of the broader range of spaces for examining mental health across the globe. However, most of the research conducted in mental health geographies across the globe remains to this date within the context of the Global North.

The chapter focuses upon four interconnected strands of space and place in relation to madness[1]: spatial epidemiologies, the 'psychiatric city', the complex spaces of care and therapeutic landscapes. The relentless process of urbanization and the emerging large cities of the Global South, signals the importance of studying the complex mental illness geographies of these spaces. First, the spatial epidemiologies, showing the variations in the incidence of schizophrenia in the urban environment with decreasing frequency away from the city centre, and its correlation with low socio-economic status, high unemployment and low social mobility, depict an interesting matrix of analysis for the social epidemiologist. Regrettably, what remains to be understood beyond the simple existence of such correlations, are the reasons explaining such patterns of spatial distribution of mental disorder in the urban environment.

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[1] The authors seem to prefer using the politicized concept of 'madness' as opposed to the more conventional medicalized notion of 'mental illness'.

Second, the 'psychiatric city' and complex spaces for care are useful constructs for analysing the spatial distribution of mental illness and mental health care structures, which may be further enhanced in an analysis from an historical perspective. The 'lunatic asylum' and its space(s) are objective representations of societal responses to the geographies of madness, shaped by the prevailing medical practices and moral values of the eighteenth and nineteenth centuries in Western nations. The images of the asylum and complex spaces of care we still see today in the former colonies in the Global South are a painful legacy of the Western lunatic asylums of the past.

Last, the notion of 'therapeutic landscapes', introduced by Gesler (1991), meant to represent places with 'an enduring reputation for achieving physical, mental, and spiritual healing', served to strengthen our understanding of the intimate interconnections between health and ill health, with space, place and identity. McGeachan and Philo present a comprehensive review of the whole range of therapeutic landscapes: from the natural and the built physical landscapes (i.e., gardens, public libraries and respite centres), to the social and symbolic environments, to the more culture-specific landscapes among Amerindian populations, to the landscapes of the mind or entirely imagined landscapes (Rose 2012).

Examining mental health and place from these geographical perspectives enables us to understand the complexities of asylum and post-asylum health care. Geographical approaches endorse the critique of 'one size fits all' when searching for delivery of mental health services which are socially relevant and culturally sensitive to context. When looking through the geographical lens at the individual dimensions of mental illness, the multidimensional and multi-scalar dimension comes to the fore. The transition from an individual focus to larger population scales, at either the national, regional or global levels, requires a geographical approach to mental health in which the voices of local actors are incorporated into planning and implementation of mental health services.

In the future, global–local interconnections and flows of concepts and ideas will remain crucial to the political ecology framework which is driven by disease ecology, health inequalities, social justice and the contextual effects of place. Some medical geographers are appealing to the diversity of approaches and conceptual frameworks required for their discipline to grow and develop further. Curtis and Riva (2010), among others, are rightly calling for a future of geography as a discipline informed by and building on 'complexity theory', which will be absolutely essential to explain the non-linear and recursive relationships between space and place and their impact on health.

Harding (chapter 4) contributes from an historical perspective to explain how modern concepts of mental health and illness are constructed in Japan and India through a dialogue established among ancient traditions and the legacy of colonial and postcolonial systems in successive encounters with the West, especially in the late nineteenth and twentieth centuries. The central argument of this chapter is aimed at understanding GMH by looking at two different national contexts. The discussion helps us avoid the tendency to universalize psychiatric conditions and underlines the crucial importance of local (micro level) initiatives as valuable responses to mental illness and psychosocial distress when confronted with globalized (macro level), mostly Western-driven diagnostic and therapeutic procedures.

When modern mental health care was established in these two countries, evident tensions emerged between those who pursued modernity via the import of Western medical ideologies in place of centuries-old practices and traditions, and those whose priority was to further explore and promote relevant insights from their own medical traditions while warily incorporating Western medical technologies. A second, no less important source of tensions emerged when taking emotional and psychological ill health of individuals and communities as evidence of the wrong sort of cultural exchange under the 'debilitating' influence of the West. Finally, additional areas of tension and controversy were created by the confrontation of individualistic approaches to mental health care in the West with the traditional extended family system in India and the particular role played by parents in Japanese families.

According to Harding, in the late 1940s, the heated debates about mind, culture and mental health, which had peaked in India (under British rule) and in Japan in the 1900s, declined steadily to give way to other public health priorities. In India, hygiene and control of infectious diseases, especially around military settlements, was considered a priority, thus allocated the scarce resources still available, while the mental health care of Indians and Europeans was segregated until independence in 1947 and relegated to a lower priority status. Nevertheless, in the mid-1950s, the exchange of therapies with the West was bidirectional and somewhat more balanced: while India contributed to Western mental health therapies with yoga and transcendental meditation, Japan added to the same therapeutic repertoire with Zen (i.e., seated meditation), and Morita and Naikan therapies drawing from centuries-old Buddhist insights.

Harding deepens his analysis of the debate in the late nineteenth and twentieth centuries in India over how mental health relates to Indian culture and medical traditions. The 1912 Indian Lunacy Act remained as such until 1987, when a new law was adopted with an emphasis placed upon treatment rather than custody. The new Act in 2014 updated many of the regulations, including patient rights to appeal doctors' decisions, the decriminalization of suicide, restricting psychosurgery and banning electroconvulsive therapy (ECT) without anaesthesia. In 1954, mental health institutions were created at the national level for research and training, such as the All-India Institute of Mental Health, which later became the National Institute for Mental Health and Neurosciences (NIMHANS) in Bangalore, which contributed to decentralizing and demystifying mental health care, with the provision of basic psychiatric training of PHC workers.

India continued playing an important role in the globalization of mental health ideas up to the present. Harding poses as an example the power exerted by WHO in India's postcolonial relationship with the West, with the influential role given to Indian psychiatrists working within WHO, and the preferential funding allocated to mental health programmes in India in the 1970s. More recently, the WHO Mental Health Gap Action Programme (mhGAP) and the emergence of the MGMH may be seen as part of the global influence exerted by Indian psychiatry across the world.

The restructuration of mental health care in Japan followed a very different pattern, under the strong influence exerted during the US occupation (1945–1952) by American psychology and the adoption of the Mental Health Law (1950), which was responsible for establishing a network of psychiatric hospitals countrywide. Since then, critical thinking emerged in Japan about the ideas of 'self' (i.e., the *amae* theory), situated at the intersection of psychiatry, social psychology and social and cultural criticism, and was among the most notable contributions of Japanese ideas to GMH.

In conclusion, Harding offers us striking examples of how historical forces in both Indian and Japanese medical and religious traditions have played such a crucial role in the emergence of GMH ideas and practices, not only generating new therapeutic approaches to mental illness but also contributing innovations in family psychiatry—in the Indian case—and community-based psychiatry in the Japanese case.

In their chapter, Jenkins and Kozelka (chapter 8) focus on problems of efficacy and validity associated with the provision of mental health services, more specifically in the uses of pharmacological treatment for serious mental illness. The authors convincingly argue for the crucial importance of cultural understanding when delivering clinical interventions, whether pharmacological or psychosocial, in the treatment of severe mental disorders.

Ethnographic accounts in different cultures show that persons and families living with mental illness are confronted with difficult decisions when taking psychotropic drugs, which always entails some degree of distress, considerable cultural dissonance and social stigma. The authors conclude that

> attention to how these cultural forces impact the course and outcome of treatment will be critical to formulating successful GMH interventions.

Studies conducted in both high- and low-income countries (e.g., USA and Ghana) consistently show high discontinuation rates (75–80%) of psychotropic medication, but there is scarce empirical data to explain the reasons for this. Most often, the discontinuation rates are explained by failures in logistics or lack of resources. On the other hand, health care providers must overcome their prejudice that the discontinuation of the medication is simply a problem of patient 'compliance' or lack of 'adherence' to treatment.

Jenkins and Kozelka start from the fundamental assumption that scaling up GMH services, including the use of psycho-pharmaceuticals, 'should be paralleled with an equal scale-up of culturally meaningful psychosocial services'. The authors further consolidate their claim by citing Read's work in Ghana (2012), by which after taking medication, a return to social functioning is generally more valued than symptom reduction. In short, taking psychoactive drugs and feeling better is a complex, nuanced process, which is driven by a number of social and cultural forces shaping the acceptability (compliance) or rejection (noncompliance) of treatment and medication. This process requires negotiation and renegotiation between the health provider and patient and above all careful fine-tuning, collaborative listening and active engagement with patients and their families as a precondition to successful treatment and compliance.

The main contribution of the chapter is to create awareness that the scaling-up of GMH services is not a simple matter of facilitating access to treatment, but should be understood as a more nuanced process beyond simple prescription, entailing a culturally informed understanding of the interface between patient and health provider, engagement with patients and their families and simultaneous attention to pharmacological treatment in tandem with the psychosocial interventions.

White and Eyber (chapter 7) contribute to this section with a critical analysis of the key concepts of 'subjective wellbeing' (SWB) and 'psychological wellbeing' (PWB) in the Global South, including the discussion of 'happiness'. They further examine the notion of *buen vivir* (living well) in the Latin American region, and present all of these as categories of wellbeing and therefore of relevance to GMH policy and practice.

The construct of SWB may be measured by how happy people are with their lives (i.e., the hedonic approach), which is equivalent to life satisfaction, also used as an indicator of 'global happiness' in economic surveys. White and Eyber review the most frequently used scales to measure SWB, which in general aim to assess 'how happy' people are, rather than attempting to find what happiness means. The construct of PWB by contrast to SWB, focuses on the substantive content of what constitutes positive mental health or optimal psychological functioning (eudaemonic approach) or what it means for a human being to 'flourish'. These new approaches are mostly derived from positive psychology and happiness economics, both positivist and empirical in orientation, in many ways different from the earlier philosophical and discursive traditions in non-Western countries defining happiness and wellbeing from a theoretical perspective.

The most substantive contribution made by White and Eyber to the discussion of SWB and PWB and the broader notion of happiness is the critical analysis of these constructs. In the first place, they acknowledge the grounding of these concepts in North American quantitative psychology and its unquestionable commitment to a methodological and ontological individualism. Second, they point at both SWB and PWB as measured mostly using quantitative methodologies and therefore reflecting the biases of universalistic approaches (i.e., *etic* as opposed to *emic* categories, close-ended rigid scales, social desirability bias etc.), over contextual ones.

In the last sections of the chapter, the authors make an effort to move away from these positivistic categories of wellbeing and discuss more contextual approaches under the title of 'psychosocial wellbeing'. In describing the main trends of psychosocial wellbeing, they distinguish the notion of 'inner wellbeing', as developed by S. C. White, on research conducted in India and Zambia. Inner wellbeing is defined as 'what people think and feel they are able to be and do' and encompass seven interrelated domains: economic confidence, agency and participation, social connections, close relationships, physical and mental health, competence and self-worth, values and meaning. However, the notion of 'psychosocial wellbeing', as proposed by White et al. (2014), can be criticized as being mostly focused on the intra-psychic and disconnected from real life (physical, material, cultural and social) and therefore of little relevance to the actual population being studied. A more holistic understanding of the notion of psychosocial wellbeing was attempted by the so-called Psychosocial Working Group (PWG), in connection with exposure to potentially traumatic events (such as armed conflict, war or natural disaster). The group described psychosocial wellbeing as a construct related to three domains: human capacity, social ecology and culture and value system.

According to White and Eyber, the manual developed by the Interagency Standing Committee (IASC) called *Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (2007)

> ha[s] contributed to a reduction of the tensions between the psychosocial and psychiatric paradigms by establishing the contributions that each can make for different segments of the population. (pp. XX)

However, the IASC manual's effectiveness continues to be contested by many as it represents above all the experts' opinion (mostly psychiatrists and psychologists) and to a lesser extent the general common sense. The recommended psychosocial interventions are insufficiently tested in real-field situations and to date little evidence exists of their effectiveness or fitness-for-purpose (Pedersen et al. 2015).

Finally, White and Eyber discuss the related notion of *buen vivir* (translated as 'living well together'), which has been described as an equivalent to the notion of 'wellbeing' as expressed among some indigenous populations of the Andean region (Bolivia, Peru and Ecuador) in Latin America. *Buen vivir* represents a circular rather than linear concept, and emphasizes reciprocity—an important Andean value concerning the flow of resources and social relations with others (family, friends, neighbours) (Mayer 2004). Above all, *buen vivir* represents a culture-specific notion, which may hold different meanings for different people. For some it may be more concerned with material possessions, while for others it may signal good social interactions or even a balanced status in the relations between man and the environment. As such, the term *buen vivir* is constructed at the local level, and therefore has limited universal or global applicability. The discussion led by White and Eyber on the main trends in the literature with respect to positive mental health, and the associated notions of well-being, happiness and *buen vivir*, is still at the beginning of a long road and reveals the lack of consensus on its meanings and the existing gaps in the ways to measure it, yet it remains a highly relevant subject to GMH.

Thornton's chapter (chapter 3) focuses on the relations between cultural idioms of distress and the *Diagnostic and Statistical Manual*—5th edition (DSM-5, APA 2013) taxonomy of mental illness from a philosophical perspective. In previous DSM versions, the cultural idioms of distress, also known as 'cultural-bound syndromes', were described as culture-specific patterns of bizarre or aberrant behaviour or troubling experience that may or may not be linked to a particular DSM diagnostic category (APA 2000). As Thornton explains, this concept is replaced in the DSM-5 by three constructs: cultural syndromes, cultural idioms of distress and cultural explanations. After discussing the issue of validity of the cultural syndromes within the new psychiatric taxonomy and the issue of cultural sensitivity in the Cultural Formulation, Thornton further illustrates the case with the example of '*khyal*'. This cultural syndrome, which has been described among Cambodians, consists of dizziness, palpitations, cold extremities, shortness of breath and other symptoms overlapping with other related conditions in the DSM-5: panic attacks, panic disorder, generalized anxiety disorder, agoraphobia, PTSD and illness anxiety disorder. The fact that '*khyal*' is described in the DSM-5 under the 'Glossary of Cultural Concepts of Distress' poses the question whether any cultural syndrome in the DSM-5

> can simultaneously aim for validity whilst admitting cultural variation. (pp. XX)

Thornton concludes that in spite of cultural concepts of distress being acknowledged in both the introduction and main body of the DSM-5, their articulation and description are constrained to an appendix and are left out of the taxonomy of mental disorders, thus challenging the idea of universal diagnostic categories.

The classification of mental illnesses represents an old tradition in psychiatry. According to Goldstein (1987), 'console' and 'classify' are the two founding principles of modern psychiatry from the eighteenth century onwards. 'Consolation' grows out of a religious tradition, while 'classification' emerges from the scientific inclination of psychiatry as a profession and its need for a reliable diagnostic system (Fassin and Rechtman 2009). The DSM and the International Classification of Disease (ICD) are classification systems allowing mapping of the psychiatric and medical domains, and the role of diagnosis is to determine a patient's location within the category borders represented by the system of classification. The borders of the classification can be seen as products of history and are changeable according to the prevailing theories of illness and attributions of causality at the time. However, classificatory systems are useful tools because they enable communication between practitioners, and with their patients and families, are used to indicate specific clinical interventions, and hold predictive and added forensic value. In the decade prior to DSM-5's publication, Thomas Insel, former Director of the National Institute of Mental Health (NIMH), expressed the hope that the forthcoming manual would classify and diagnose disorders based on biomarkers, such as disorder-specific brain activity patterns or chemical and structural changes. Therefore, it is little surprise that cultural concepts of distress are left behind in the DSM-5. A second statement, issued jointly with the NIMH's president-elect, stressed that the DSM remained a key resource, but still insisted on the need for a diagnostic system that more directly reflects modern brain science. However, this remains an aspiration, which may be premature given current knowledge of the brain and the aetiology of mental disorders. The number of disorders listed in the DSM rose from 106 to 374 between the first and fourth editions; similarly, the criteria by which a diagnosis is reached have grown ever more inclusive. However, only a fraction (about 3%) of DSM disorders today have any known biological causes. Future classifications will certainly need to be based on different premises and better understanding of neurosciences and other disciplines relevant to psychiatric disorders, which are likely to lead to diagnostic systems that map much more clearly onto the functions and dysfunctions of the brain.

Note from the Editors Dr Duncan Pedersen sadly passed away on 26 January 2016 while completing fieldwork in Chile. Duncan died as he had lived—demonstrating a true commitment to promoting understanding about the needs of diverse populations across the globe. He was insightful and progressive in his thinking until the end. Speaking at the final plenary of the 2015 Canadian Conference for Global Health on 7 November 2015, Duncan urged attendees to be more mindful of the effects that larger determinants and structures have on health, and the need to promote social justice in the context of factors such as geopolitical tensions and climate change (http://www.csih.org/en/blog-3/). In an online post in October 2015, Pedersen and Kirmayer highlighted that 'the most serious global disparities in mental health are an intricate part of the forces of globalization and the current crises at the planetary level. Global warming, resource depletion, ecosystem degradation, poverty and social inequalities, violent conflict, war, and forced migration are among the important challenges that are shaped by cultural values and practices on both local and global-scales. This cluster of contemporary problems is part of the web of causes that contribute to the global distribution (and apparent world-wide escalation) of mental disorders and is powerfully shaping the GMH research agenda, which aims to support effective action' (see http://publications.mcgill.ca/reporter/2015/10/global-mental-health-at-mcgill-advancing-a-social-cultural-and-ecosystemic-view/).

At the time of his death, Duncan was finalizing arrangements for the *22nd Annual Summer Program in Social and Cultural Psychiatry* to be hosted at McGill University, Montreal, Canada. The title of the International Advanced Study Institute—the traditional curtain-raiser for the programme—had been confirmed as 'Psychiatry for a Small Planet: Eco-social Approaches to Global Mental Health'. The four central themes that Duncan and his colleagues had identified for the event were (1) rethinking the politics, ethics and pragmatics of GMH 'from the bottom up' to ensure the voice of diverse communities; (2) the impact of urbanization and the built environment; (3) the implications of forced migration and displacement; and (4) the impacts of climate change on the mental health of populations and communities (https://www.mcgill.ca/tcpsych/training/advanced/2016). Although Duncan's absence was sorely felt by all those who attended the event, the *Duncan Pedersen Scholarship* that was launched at the meeting will help to ensure that his legacy lives on, and that for years to come students will be afforded the opportunity to progress the values and principles that he espoused.

The commentary that Duncan had kindly agreed to write for this volume was awaiting his final revisions at the time of his death. With the permission of his family, we have included it in its unfinished form. Duncan's passing on is a great loss for the academic community and, in particular, for those involved in GMH research and practice. He will be sadly missed.

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Part II

Globalising Mental Health: Challenges and New Visions

10

'Global Mental Health Spreads Like Bush Fire in the Global South': Efforts to Scale Up Mental Health Services in Low- and Middle-Income Countries

China Mills and Ross G. White

In 2003, the World Health Organization (WHO) reported that over 650 million people worldwide are estimated to meet diagnostic criteria for common mental disorders such as depression and anxiety (2003a, p. 17). Furthermore, WHO have estimated that by 2030, depression will be the second biggest disease burden across the globe (Mathers and Loncar 2006), second only to HIV/AIDS. Despite this global 'burden' of mental disorders and their growing prevalence, the 2001 World Health Report stated that '[m]ore than 40% of countries have no mental health policy and over 30% have no mental health programme', meaning that 'there is no psychiatric care for the majority of the population' (WHO 2001a, pp. 3, xvi). Most of the countries that do not have a mental health policy are low- and middle-income countries (LMICs).

In light of this, the Movement for Global Mental Health (MGMH)—an increasingly influential international network of individuals and organizations—was launched in 2008 (see www.globalmentalhealth.org). The MGMH aims 'to close the treatment gap for people living with mental disorders worldwide' (Patel et al. 2011, p. 88)—'the gulf between the huge numbers who

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This is a quote from a personal communication between China Mills and Mohamed Ibrahim, a PhD student at Simon Fraser University, Canada, and a nurse and social worker in Kenya.

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need treatment and the small minority who actually receive it' (WHO 2001, p. 6). To achieve this, it aims '[t]o scale up the coverage of services for mental disorders in all countries, but especially in low-income and middle-income countries' (Lancet Global Mental Health Group 2007, p. 87) and believes that this scale-up is 'the most important priority for global mental health' (Lancet Global Mental Health Group 2007, p. 87).

Scaling-up has been defined as the process of increasing the number of people receiving services, increasing the range of services offered, ensuring these services are evidence based, using models of service delivery that have been found to be effective in similar contexts, and sustaining these services through effective policy, implementation, and financing (Eaton et al. 2011). What is meant by 'mental health services' tends to involve (dependent on the type of 'disorder') both pharmacological and psychosocial interventions, though medication seems to be given priority as first-line treatment in certain circumstances, for example, for schizophrenia and psychotic disorders, and in areas seen as being resource poor (Lancet Global Mental Health Group 2007). In an effort to outline strategies for scaling up mental health provision in LMICs, WHO published two key documents: the Mental Health Gap—Action Programme (mhGAP-AP) and the Mental Health Gap—Intervention Guide (mhGAP-IG). The mhGAP-AP outlines key steps for scaling up mental health services in LMICs, while the mhGAP-IG presents integrated management plans for priority conditions, including depression, psychosis, bipolar disorder, and epilepsy, in LMICs.

Concerns have been expressed that the mhGAP initiatives are largely based on mental health services in high-income countries (HICs) that have been heavily shaped by biomedical psychiatry (White and Sashidharan 2014a). This is occurring at a time when 'psychiatry is under criticism as a basis for mental health service development' (Fernando and Weerackody 2009, p. 196). As such, calls to scale up services in LMICs are co-occurring with calls to scale down the role of psychiatry in many HICs. Fernando voices this concern when he asks: 'Has psychiatry been such a success here [in HICs] to entitle us to export it all over the world?' (2011, p. 22).

This chapter asks a number of pertinent questions aimed at facilitating critical reflection on efforts to scale up mental health services in LMICs in order to explore the complexities of this endeavour. In part, this involves paying attention both to more general critiques of psychiatry in HICs—for such critiques may still apply or magnify when exported globally—and to critiques that are focussed more specifically on the export of mental health services dominated by psychiatry to LMICs. The questions to be considered include:

Is the validity of psychiatric diagnosis being overemphasized? Is a preoccupation with eliminating symptoms of illness obscuring understanding about what constitutes 'positive outcomes' for individuals experiencing mental health difficulties? Is the 'treatment gap' in LMICs as large as it is reported to be? Are alternative forms of support being neglected? Are social determinants of mental health being sufficiently considered? Is the evidence base for GMH sufficiently broad, and has the efficacy of 'task-shifting' been sufficiently demonstrated?

Is the Validity of Psychiatric Diagnosis Being Overemphasized?

The WHO World Health Report (2001, p. x) states that '[w]e know that mental disorders are the outcome of a combination of factors, and that they have a physical basis in the brain. We know they can affect everyone, everywhere'. Yet critical psychiatrists, such as Joanna Moncrieff, point out that in fact there is 'no convincing evidence that psychiatric disorders or symptoms are caused by a chemical imbalance' within people's brains (2009, p. 101). Moncrieff (2009) makes a distinction between 'disease-centred' and 'drug-centred' models for the action of psychotropic medications. The 'disease-centred' model suggests that the medications work by directly addressing the biological mechanisms that give rise to the mental disorder. On the other hand, 'drug-centred' models propose that psychotropic medications act by inducing abnormal or altered mental states. She points out that there is little evidence to support the former. Furthermore, there is much research that questions the validity and reliability of certain mental disorders, particularly the schizophrenia label (Boyle 1990/2002; Bentall 1990, 2003)—a diagnosis that some feel should be abolished altogether rather than exported globally (Hammersley and McLaughlin n.d.). Bentall's (1990) criticisms regarding the diagnosis of 'schizophrenia' include the following:

1. Service users' presentations do not fall into discrete types of psychiatric disorder as is commonly assumed.
2. Service users experience a mixture of symptoms of schizophrenia and non-schizophrenia symptoms.
3. There is no clear distinction between symptoms of schizophrenia and normal functioning.
4. A diagnosis of schizophrenia does not predict outcome or response to treatment.

These are issues that have also been identified with other forms of psychiatric diagnosis. Indeed, the US National Institute for Mental Health has opted to move away from using the Diagnostic and Statistical Manual approach (advocated by the American Psychiatric Association) and the International Classification of Disease approach (advocated by the WHO) for psychiatric diagnosis because 'the boundaries of these categories have not been predictive of treatment response. And, perhaps most important, these categories, based upon presenting signs and symptoms, may not capture fundamental underlying mechanisms of dysfunction' (Insel et al. 2010, p. 748).

Such issues have led many critical psychiatrists, as well as mental health service users and survivors, and other professionals and researchers, for example, some psychologists (often but not solely based in HICs), to increasingly call to abolish psychiatric diagnostic systems, and/or to call for a paradigm change within psychiatry, based on evidence that, in summary, psychiatric diagnoses are not valid, do not aid treatment decisions, impose Western beliefs about mental distress on other cultures (Bracken et al. 2012; Timimi 2011, online), may increase stigma (Angermeyer and Matschinger 2005; Read et al. 2006), and are sites of institutional racism for ethnic minorities in many HICs (Fernando 2010). Despite these critiques, mental health services in HICs continue to operate primarily within the parameters of these problematic biomedical diagnoses and forms of treatment.

In spite of the concerns regarding the validity and reliability of psychiatric diagnoses, the mhGAP initiative highlights a range of priority psychiatric diagnoses that services should be scaled up to address—including schizophrenia. Reflecting on the tensions that can exist in applying mental health diagnostic criteria in LMIC settings, Dr Rosco Kasujja (a clinical psychologist in Kampala, Uganda) states that

> There are so many conditions that are specific to Uganda or other LMICs. However, I was trained only to use the DSM-IV, and hence my assessment may be inappropriate or irrelevant. Is the client coming to me to be relieved of distress or just to get a label? Such is the extent of distortions surrounding diagnostics, whereby practitioners spend more time trying to find a label than finding the best way to help the client feel better. (Kasujja 2014, p. 4)

There is a further concern that the portrayal of mental distress as biological may be ideological in that it enables a sidestepping of critique of the deleterious effects of social arrangements and systemic inequality, overlooks the complexity of lived experience, and potentially serves the financial interests of the pharmaceutical industry (Kirmayer 2006; Shukla et al. 2012). A key issue then in framing distress as biomedical lies in implications for treatment, which currently tend to be dominated by medication.

Is a Preoccupation with Eliminating Symptoms of Illness Obscuring Understanding About What Constitutes 'Positive Outcomes' for Individuals Experiencing Mental Health Difficulties?

Global Mental Health (GMH) has been likened to a moral crusade that is seeking to respond to 'a failure of humanity' (Kleinman 2009, p. 603). Patel et al. (2006, p. 1312) call for a move beyond the 'scientific evidence base' of particular treatments (which are taken as well established) and push the 'moral case', claiming that 'it is unethical to deny effective, acceptable, and affordable treatment to millions of persons suffering from treatable disorders'. The denial of effective and sometimes life-saving treatments in LMICs is a serious concern that has played out particularly around communicable diseases, such as HIV/AIDS, and is often linked to intellectual property rights and the pharmaceutical industry's pursuit of profits (Shah 2006; Soldatic and Biyanwila 2010). While the WHO and MGMH's promotion of medications as first-line treatment for many mental disorders may be a topic of debate, particularly in terms of benefits that this might serve the pharmaceutical industry, it should be noted that some proponents have argued that psychotropic medication should be exempted from patenting in order to reduce costs (Patel et al. 2006).

Casting GMH as a moral concern has created a context in which there is an imperative for people to act, and for this action to be taken quickly: according to the Lancet Global Mental Health Group (2007, p. 370), 'the time to act is now'. However, this urgency for action is not universally welcomed by people working in LMICs as it may lead to little consultation with local peoples and to resources being spent on the development of services that are neither appropriate nor effective (Kasujja 2014).

Yet what if the scientific evidence contains evidence that the treatment (often psychotropic medication) being scaled up is not always effective, acceptable, or affordable? What if evidence points to the use of this medication as sometimes ineffective, or at worst, harmful? When examining the evidence base for the use of psychotropic medication, a number of issues come to light. First, little is known about how psychotropic drugs actually work (Moncrieff 2009); and some trials (particularly for anti-depressants) have found that drug-placebo differences are not statistically significant (Kirsch 2009). Second, there is a growing body of research that points to the harm caused by long-term use of some psychiatric medications (Breggin 2008; Luhrmann 2007; Whitaker 2010). For example, antipsychotic medications have been found to contribute to increased morbidity (metabolic disorders and cardiovascular conditions) and risk of premature mortality linked to sudden cardiac death (Alvarez-Jiminez et al. 2008; Ray et al. 2009; Weinmann et al. 2009). In trials of anti-depressants, significant adverse effects have been found, including increased risk of suicide (Healy 2006). Furthermore, a number of psychiatric drugs, and particularly the psycho-stimulants often prescribed to children, are highly addictive (Timimi 2002).

Third, there is a lack of clear consensus among mental health professionals and people with mental health difficulties themselves about what constitutes a 'positive outcome' from such difficulties (White 2013; White et al. 2016). Traditionally, psychiatry has been concerned with eradicating symptoms of mental illness. However, it is important to appreciate that clinical symptoms do not necessarily improve in parallel with social or functional aspects of service users' presentation (Liberman et al. 2002). Evidence suggests that individuals who discontinued their medication following a first episode of psychosis at seven-year follow-up had more than double the chance of achieving functional recovery (i.e. 40 vs. 18%) (Wunderink et al. 2013). In line with these findings, Morrison et al. (2012) have called for greater patient choice in decisions being made about whether antipsychotic medication is required to facilitate recovery from psychosis.

In recent times, conceptualizations of outcome from mental health difficulties have been extended, from a narrow focus on symptom remission alone to a broader interest in individuals' subjectively appraised levels of functioning (White et al. 2016). Consistent with this approach, the WHO has adopted a specific focus on 'mental health' rather than simply focusing on trying to treat mental illness. According to the Mental Health Action Plan 2013–2020 (WHO 2013), mental health is 'conceptualized as a state of wellbeing in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community' (WHO 2013).

Fourth, when attempts have been made to measure outcomes for people diagnosed with schizophrenia across cultures (in terms of relief of psychiatric symptoms and social recovery), outcomes in 'developing' countries have been found to be better. These findings were reported by WHO's major studies: the International Pilot Study for Schizophrenia, the Determinants of Serious Mental Disorders (DOS-MED), and the International Study of

Schizophrenia (WHO 1973, 1975, 1979; Jablensky and Sartorius 2008). Despite flaws in its methodology (Fernando 2014), it would seem that the context for recovery from what may be called 'serious mental illness' may well have been better in India and Nigeria than it was in 'developed' countries at that time. Halliburton (2004) suggests this may have been due in part to the availability and plurality of indigenous systems of healing.

Lastly, evidence suggests that focusing on treatment of symptoms of mental illness by use of psychotropic medication may also have harmful effects on a community by potentially discrediting indigenous forms of healing, and foreclosing interventions and analysis that examine contextual and socio-economic contributors to distress (Read 2012; Jain and Jadhav 2009; Mills 2014b). These issues will be discussed in more detail in subsequent sections.

Is the 'Treatment Gap' in LMICs as Large as It Is Reported to Be?

Much of the call to scale up mental health services is based on the assumption that there is a 'treatment gap'—that there is a high need for mental health services in LMICs and that this need is not met. Within GMH literature, this partly seems to imply that current services and resources for mental health simply do not exist, and partly that what does exist is inadequate, particularly in respect to being 'unscientific'. As Kasujja (2014, p. 3) puts it—'scaling-up implies that LMIC mental health systems need some kind of upgrading, which implies, in other words, that they are rotten, inadequate, insufficient or in a state that causes concern'. Such assumptions are problematic and need to be addressed. Patel et al. (2011, p. 1442) call for the Mental Health Gap Action Programme (mhGAP) guidelines (specifically developed to aid treatment decisions in non-specialized health care settings in LMICs) to 'become the standard approach for all countries and health sectors', meaning that 'irrational and inappropriate interventions should be discouraged and weeded out'. Here 'scaling up' also involves a process of 'weeding out'. That which is being scaled up is constructed as rational and appropriate, and that which needs weeding out is 'irrational'. However, the question of who decides what counts as appropriate or irrational is overlooked. Drawing on the work of Fernando (2012) and Sax (2014), Kirmayer and Pedersen (2014) suggest that the notion of a treatment gap 'privileges mental health services and interventions by mental health professionals and ignores or downplays community-based and grass-roots approaches' (p. 764).

The assumption that GMH is scaling up psychiatry onto an empty terrain (i.e. that few resources currently exist in LMICs) is problematic because, as with the assumption that alternatives do exist but are 'irrational', it overlooks the potential cultural validity of alternative forms of support, which may range from informal support within a community, to other forms of healing. Moreover, a number of LMICs already have psychiatric systems in the form of large asylums, often as legacies of colonialism (Ernst 1997), and that continue as sites where multiple human rights abuses occur (WHO 2003b, p. 23). Such abuses are acknowledged by the MGMH, which calls for a move away from large-scale institutions and encourages community and out-patient forms of care. However, the MGMH does this with (1) little discussion of the problems that care in the community has run into in the HICs where it is enacted and (2) little acknowledgement of how the MGMH's activities may reproduce (neo)colonial power relations (see Fernando 2014; Mills 2014a; Mills and Fernando 2014).

Are Alternative Forms of Support Being Neglected?

It is suggested that the WHO and the MGMH fail to consider how efforts to 'scale up' mental health services may serve to undermine or subjugate local understanding and forms of support (White and Sashidharan 2014a). Across the world, a multitude of 'alternative' systems of healing exist that reflect different worldviews and have shaped understanding about the distress that people experience. For example, a broad range of 'indigenous' or 'traditional healing' systems exist (Davar and Lohokare 2009) which have predated the development of psychiatry as a specific branch of medicine. Some forms of support however have developed as alternatives to, or in opposition to, psychiatry. In the Global South, examples of this include the work of Bapu Trust (in India), and the Pan African Network of People with Psychosocial Disabilities (PANUSP) (South Africa). These organizations advocate locally relevant healing, such as meditation and drumming, alongside peer support, and understand people who experience distress as the 'experts' (PANUSP 2011/2014). They are among a growing number of user/survivor organizations that explicitly develop alliances with international user and survivor organizations, such as the World Network of Users and Survivors of Psychiatry (WNUSP), Mental Health Worldwide, and MindFreedom International. Alongside this, several organizations throughout the Global North provide advocacy, support, and alternative treatment approaches, such as the *Hearing Voices Network*, the

Soteria Network, and the *Icarus Project*, and are increasingly establishing links with partner organizations in the Global South.

Rather than focusing specifically on psychiatric diagnoses and treatments that may not be valid or desirable in LMICs, White and Sashidharan (2014b) propose an alternative approach in which social problems linked to difficulties with the emotional well-being of people in particular locations are targeted. Specifically addressing these social problems (e.g. marginality, gender-based violence, substance use, stigma associated with HIV/AIDS) may provide an opportunity to utilize bottom-up approaches to understanding and addressing emotional distress that are informed by effective forms of support that have traditionally been used to alleviate this distress. They suggest this will maximize the extent to which interventions will be shaped by local priorities and be bought into by local stakeholders.

A key issue relating to GMH discourse is the lack of reciprocity regarding the onus on LMICs compared to HICs to implement change in mental health policy and practice (White and Sashidharan 2014b; Procter 2003; White et al. 2014). Traditionally, the transfer of knowledge about mental health has been unidirectional. This has served to downplay the need for critical reflection on how mental health difficulties are understood and addressed in HICs. For example, Collins et al. (2000) reflect on how the experience of developing countries might influence reform within the National Health Service in the UK, concluding that 'while the (global) South can learn from the (global) North, so too can the North from the South' (p. 87). For example, it may be that mental health services in HICs (such as the UK or USA) could better engage with migrant populations by being more sensitive to the diversity of beliefs and practices associated with their distress. In addition, McKenzie et al. (2004) previously highlighted important lessons that HICs can learn from LMICs in terms of models for the provision of mental health care. White et al. (2014) highlight, however, that rather than restricting the analysis to models of care provision, there is a need for critical reflection on the assumptions and rationale that underlie models of explanation advocated in HICs.

A greater willingness to embrace alternative ways of conceptualizing mental health difficulties, pluralistic methods of support in HICs, and 'counterflows' of knowledge from LMICs to HICs, may facilitate people to engage with forms of support that they believe to be appropriate for them (White et al. 2014). Mindfulness, a practice aimed at facilitating non-judgmental present moment awareness, provides an example of a counterflow. Mindfulness has its roots in meditative practices used in Buddhism. Over the last 25 years, writers such as Jon Kabat-Zinn and Thich Nhat Hanh have helped to promote mindfulness as a way of enhancing well-being, and it is now widely used for treating a range of mental health difficulties in HICs (Germer et al. 2013). There are accounts of reciprocal mental health and well-being work being done between countries of the Global North and South, for example, between Canada and Cameroon (Suffling et al. 2014). However, it should be noted that the discrediting of alternative and indigenous forms of healing is also a daily reality in some countries of the Global South where mental health care is dominated by bio-psychiatry (Jain and Jadhav 2009). For example, in India, it is reported that alternative forms of healing are increasingly 'vanishing' (Davar 2014).

Are Social Determinants of Mental Health Being Sufficiently Considered?

A recent report jointly published by the WHO and Calouste Gulbenkian Foundation (2014) highlighted that risk factors for many common mental disorders are heavily associated with social inequalities, whereby 'the greater the inequality the higher the inequality in risk' (p. 9). The importance of addressing macro-level determinants of mental well-being is also highlighted in the WHO Mental Health Action Plan 2013–2020, which states that '[d]eterminants of mental health and mental disorders include not only individual attributes such as the ability to manage one's thoughts, emotions, behaviours and interactions with others, but also social, cultural, economic, political and environmental factors such as national policies, social protection, living standards, working conditions, and community social supports' (WHO 2013, p. 7). In particular, poverty, and its psychological and emotional consequences, is often highlighted as a potential determinant of mental health difficulties. For example, indebtedness to moneylenders is seen to play a key role in the high rates of farmer suicides in South Asia (Patel and Kleinman 2003). Laudable attempts to explore the social determinants of mental health tend to conceptualize social factors as a 'trigger' for underlying vulnerabilities, and furthermore, often take recourse to using psychiatric diagnostic categories to measure the mental health impact of social determinants (Mills 2015). Some argue that this leans towards an individual-oriented materialistic approach to social determinants of health that are consistent with neoliberal governance and a free market rationale, and that fail to acknowledge that social determinants are themselves determined by political and economic forces (Das 2011; Raphael 2006). For example, GMH advocates would do well to investigate the relationship between the aforementioned farmers' distress and agricultural trade liberalization and global capitalist food production chains (Mills 2014a; Das 2011). Thus, it may be that the mention of social determinants by largely biomedical organizations such as the WHO, enables a discursive acknowledgement of mental health as affected by the social, while potentially diverting attention and resources from more widespread structural or systemic change (Mills 2014a). This points to a need to move away from the individualisation of distress by calling attention to the structural determinants of mental health and well-being more widely; the intergenerational trauma of social inequality, chronic poverty and colonialism, and the ways that intersecting forms of oppression (such as racism, ableism, sexism) may compound mental distress.

White et al. (2016) have recently called for GMH initiatives to utilize a welfare economics framework known as the Capabilities Approach (Sen 1992; Nussbaum 2006) to guide efforts to promote well-being. The Capabilities Approach places specific emphasis on tackling sources of social injustice and structural violence operating at a macro level that limit the extent to which individuals and communities can fulfil their potential (e.g. discrimination on the basis of gender, ethnicity, caste, physical/mental capacity, etc.). The application of this framework to GMH emphasizes the need to understand (1) what individuals in a particular setting regard as important to how they want to live their lives, and (2) the personal and structural factors that can either promote or hinder people's opportunity to engage in behaviours that are in keeping with what they hold to be of value. Moving forward, there is certainly a need for GMH initiatives to demonstrate a purposeful shift in approach to systematically address the social determinants of mental health and well-being. This will require greater engagement with a wider range of stakeholders including service users, social scientists, non-governmental organizations, and government ministries.

Is the Evidence Base for GMH Sufficiently Broad?

Another issue of ongoing contention in GMH discourses relates to the extent to which interventions should be 'evidence-based'. Leading figures from the MGMH and the authors of the mhGAP initiatives have emphasized the importance of scaling up 'evidence-based' interventions (Lancet Global Mental Health Group 2007; WHO 2008, 2010). However, it is widely recognized that there has been a dearth of research conducted into mental health in LMICs (Sharan et al. 2009) in particular, investigating the efficacy of psychosocial interventions (Brooke-Sumner et al. 2015). Although >80% of the global population lives in LMICs, over 90% of papers published in a three-year period in six leading psychiatric journals came from Euro-American countries (Patel and Sumathipala 2001). This has led Summerfield (2008) to posit that the predominance of 'Western' frames of reference for categorizing and measuring mental health difficulties mean that the evidence base for mental health interventions is not universally valid for the global population.

In terms of particular research frameworks, the MGMH has aligned itself closely to the Evidence-Based Medicine (EBM) paradigm. According to EBM, the accolade of the best form of 'evidence' is awarded to meta-analyses of randomized controlled trials (RCTs). Consequently, the RCT research design is considered the 'gold standard' of biomedical knowledge production over any other form of observational knowledge (Rolfe 1999; Webb 2001; Timmermans and Berg 2003). It seems that the objectivity of procedural logic and technical conventions that EBM advocates have served to strengthen MGMH claims about the universality of its approaches (Bemme and D'souza 2014). However, the capacity for EBM to be applied in different parts of the globe must not be conflated with an assumption that the intervention being evaluated is equally valid across these settings (Bemme and D'souza 2014).

Bemme and D'Souza (2014) point out that RCTs in Global Health have been criticized for being costly, insensitive to context, and not necessarily producing better outcomes (Adams 2013; Farmer et al. 2013), and for potentially creating barriers to research in low-resource countries (Hickling et al. 2013). For example, it has been suggested that EBM does not foster the critical thinking that it supposedly encourages, but instead promotes 'dependency on pre-interpreted, pre-packaged sources of evidence' (Upshur 2006, p. 420). Staller (2006, p. 512) suggested that a monolithic notion of 'best evidence' which excludes other forms of evidence is 'reductionist and dangerous'. This has prompted Kirmayer (2012) to suggest that evidence-based practices originating from HICs may not be culturally appropriate, feasible, or effective in other settings. Furthermore, RCTs designed to investigate particular interventions have been criticized for focussing too much on the internal validity of the trial, being preoccupied with the question of efficacy rather than broader issues such as reach, implementation fidelity, and sustainability (Glasgow et al. 2006). Drawing on 'realist' philosophy, researchers have expressed concerns about the positivistic epistemology underpinning RCTs suggesting that the methodology is overly controlled and too disconnected from the way in which participants interact with their environments (Bonell et al. 2012; Marchal et al. 2013). It could therefore be argued that efforts to promote mental health and well-being are being restricted by the prejudicial attitudes relating to what forms of knowledge actually count.

There is a risk that a slavish adherence to the EBM technical paradigm may serve to disenfranchise large sections of the global population from accessing effective forms of support that are not deemed to be evidence based within its terms. Tol et al. (2012) proposed that tensions between 'research excellence' and 'research relevance' have given rise to an apparent disconnect between different stakeholders regarding mental health research priorities in humanitarian settings. He suggests that researchers' preoccupation with adhering to rigorous research designs may have inadvertently served to shift the research focus away from relevant local issues. Fernando (2012) picks up on the importance of consulting with individuals with a lived experience of mental health difficulties when identifying research priorities. She considers this to be pivotal to conducting 'ecologically sound' research. Unfortunately however, the forms of evidence valued by EBM tend to give little or no priority to service users' preferences (i.e. values) or narratives (i.e. meaning) (Thomas et al. 2012). In recent years, concerted efforts have been made, particularly in HICs, to involve service users in research through projects such as the Service User Research Enterprise (http://www.kcl.ac.uk/prospectus/group/service-user-research-enterprise--obr-sure-cbr-) and Patient and Public Involvement (PPI) in the UK. It is hoped that initiatives of this kind will facilitate research opportunities that reflect priorities identified by service users and utilizes a broad range of methodologies. Yet to date, similar initiatives have not been launched in LMICs.

Kirmayer (2012) highlights that different cultures privilege different ways of gathering and synthesizing knowledge, and that researching these ways of knowing will require

> a wide range of methods including those of the humanities and social sciences which can expose the historical roots, contextual meaning and rhetorical force of particular ways of construing self and other, in health and illness (p. 255).

As such, the 'local' context should be the starting point of the research rather than an endpoint consideration about how a particular intervention can be adapted (White and Sashidharan 2014b; Adams 2013). The emphasis on local concepts should include the creation of valid instruments for assessment purposes (Kirmayer and Swartz 2013; Summerfield 2008). Kohrt et al. (2016) have also highlighted the important role that anthropological approaches to understanding local context have to play in the design, implementation, and scale up of local solutions for delivering mental health support.

Acknowledging the inadequacies of the available ‘scientific evidence base’, instead of moving beyond it as Patel et al. (2006) urges, will be vitally important for deciding what can be regarded as moral and ethical in efforts to address emotional distress. In apparent acknowledgement of the limited amount of research conducted to date, Da Silva (2014, p. 3) states that

> [u]ntil robust evidence on the impact, costs and process of mental health programmes is more widely available, efforts to scale up evidence-based services will be hampered.

However, as highlighted earlier in this chapter, the ‘robustness’ of the evidence will be influenced not just by the amount of research but also by the types of intervention that are investigated and the breadth of research methodologies employed to conduct these evaluations (and a move away from an over-reliance on the EBM paradigm). The MGMH’s claims to be rooted in human rights, where the scale-up of psychiatric services is justified through a discourse of the ‘right’ to access treatment, sits uncomfortably alongside the framing of people’s ‘right’ to refuse treatment that may be inappropriate or harmful as advocated by service user and/or psychiatric survivor movements such as WNUSP. For example, the evidence mentioned earlier about the potential long-term harm of a number of psychotropic medications is not part of the MGMH’s evidence base.

Has the Efficacy of ‘Task-Shifting’ been Sufficiently Demonstrated?

The Lancet Global Mental Health Group prioritizes the development, and subsequent scale-up of interventions ‘that can be delivered by people who are not mental health professionals’ across routine care settings (2007, p. 87). This is known as task-shifting: a process involving the engaging of human resources, generally non-professional, in the care of mental health disorders (McInnis and Merajver 2011). For example, skills usually allocated to psychiatrists or clinical psychologists (who are expensive and comparatively slow to train) could be transferred to other lower-skilled occupational groups (Kakuma et al. 2011). A recent Cochrane Review conducted by Van Ginneken et al. (2013) highlighted that training and utilizing non-specialist health workers (NSHWs) may have promising benefits in improving people’s outcomes for general and perinatal depression, post-traumatic stress disorder (PTSD), alcohol-use disorders, and dementia. However, the available evidence was mostly low or very low quality, and in some cases completely absent. Importantly, the review highlighted that few studies measured adverse effects of NSHW-led care (van Ginneken et al. 2013). Although task-shifting, or task-sharing (which is considered by some to be a more egalitarian term), initiatives are to be admired for the creative ways in which logistical, training, and administrative hurdles are overcome, it is important to highlight that the jury is still very much out on whether psychiatric systems of care are the most effective model on which these efforts should be based. For example, challenges associated with task-shifting/sharing include the overburdening of already overstretched staff; inadequate training, supervision, and remuneration; and the delivery of potentially poor-quality interventions (Mendenhall et al. 2014).

To date, there has been a conspicuous lack of effort made to involve people with a lived experience of mental health difficulties in task-shifting or task-innovation. A notable exception to this is the Butabika Project[1] in Uganda (see the chapter by Hall et al. in Part III of this volume), which has placed specific emphasis on developing 'experts by experience' as peer-support workers. Reflecting on the progress of task-shifting initiatives to date, Kasujja (2014, p. 4) points out that '(w)hen experts from HIC come to LMIC, they need to involve locals—from service users to trained/experienced professionals in the field … Locals in LMIC need to be involved in key decisions and discussions taking place at the international level … task-shifting therefore needs to be rethought'.

Conclusions

Over the course of this chapter, a range of key questions have been considered about efforts to scale up services globally for mental health. The appropriateness of regarding mental disorders as primarily a psychiatric concern and a corresponding lack of emphasis being placed on social determinants of emotional distress was highlighted. In the light of ongoing doubts about the long-term efficacy of psychotropic medication and the impact that it can have on individual's physical and mental health, the ubiquitous priority allocated to this in GMH initiatives was questioned. In addition, the extent to which an over-reliance on pharmacological interventions may divert focus and resources away from researching and promoting existing or novel forms of support based on local priorities and including psychosocial approaches was highlighted. To date, the move to increase service provision for mental

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[1] The Butabika Project, Uganda (http://www.butabikaeastlondon.com/our-activities/user-involvement-heartsounds.aspx).

disorders globally has not been accompanied by efforts to improve understanding about diverse concepts of 'mental well-being'.

The chapter highlights a need for greater reciprocity between HICs and LMICs in how mental health services are designed and delivered. In particular, imbalances in the transfer of knowledge between LMICs and HICs need to be addressed, with increased recognition of alternative worldviews. The chapter argued that a preoccupation with particular forms of research evidence means that the evidence base for mental health interventions is not globally valid. Efforts to facilitate co-ownership of the research process with experts by experience have also proved conspicuously absent in the majority of research in LMICs conducted to date. There is a need to broaden the interdisciplinary scope of research into mental health difficulties across the globe to include methods advocated by social science, humanities, and economics. This will help to progress a research agenda that is inclusive of diverse themes such as cultural idioms of distress (Nichter 2010), traditional and indigenous healing practices (Davar and Lohokare 2009), the political economy of GMH governance (Howell 2011), sources of social injustice and structural violence (Nussbaum 2011; Farmer 1996), and a focus on conceptualizations of well-being espoused by the Capability Approach (Simon et al. 2013).

By incorporating critiques posited by various commentators, the chapter points out that the 'treatment gap' discourse that is widespread in GMH initiatives are skewed towards efforts to legitimize Western-style mental health interventions while simultaneously failing to recognize complementary or alternative approaches. This is in spite of growing recognition within the West that mental health services are failing to adequately deliver for those with a lived experience of mental health difficulties and their families. Although task-shifting efforts may increase the availability of human resources for addressing mental health problems in LMICs, these efforts will be in vain if the tasks that are shared are inadequate. As such, calls to 'scale up' services to better address the burden caused by mental disorders in LMICs may be serving to divert attention away from the need to reform the underlying assumptions of mental health services in HICs, and rethink the role of psychiatry in promoting well-being worldwide.

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11

Community Mental Health Competencies: A New Vision for Global Mental Health

Rochelle Burgess and Kaaren Mathias

This chapter takes interest in defining the notion of 'community' within global mental health. Specifically, it seeks to elaborate on the psychosocial processes that enable the promotion of mental health in an era where 'community-level' responses form the core of treatment approaches (see Hanlon et al. 2010; WHO 2010). It argues that 'community engagement' for mental health is a concept largely unexplored and narrowly conceptualised, with serious implications for service outcomes. It is widely argued that 'community approaches' must be locally grounded. To achieve such ends, action that extends beyond the scope of most psychosocial forms of community interventions is required (Burgess 2014; Campbell and Cornish 2010). This chapter presents two brief case studies exploring multiple approaches to the idea of 'community' mental health from around the globe. It highlights the opportunities and challenges presented by a 'community mental health competency' approach, anchored in a perspective where community voices and realities actively shape responses

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and enable communities to become self-determining agents of their own mental well-being.

Background

Mental, neurological, and substance abuse disorders have been identified as the largest contributors to years lost to disability globally (Whiteford et al. 2013). In low- and middle-income countries (LMICs) where mental health spending averages less than 25 cents per person (WHO 2011), more than 85% of mental health conditions go untreated (Saxena et al. 2007). Outcomes for individuals with mental distress are further complicated by the absence of legislation to protect their human rights, with only 36% of LMICs having mental health legislation (WHO 2013).

Amidst a climate of austerity in both high-income countries and LMICs, interventions promoting empowerment and local action in response to health problems have become increasingly popular (Lowndes and Pratchett 2012), often idealising communities as spaces of potential, shared identity, and common ideals. However, these perspectives can often gloss over the complexities of promoting community engagement—an issue that has been explored extensively in the contexts of community responses to HIV/AIDS in sub-Saharan Africa. For example, the invisible dimensions of power, position, norms, and conflicting knowledge systems have all been linked to the challenges facing community work within the HIV/AIDS response (Campbell et al. 2008; Campbell and Nair 2014; Campbell 2000; Gibbs and Campbell 2014; Burgess 2013a). Potential impacts of these issues bear relevance beyond HIV/AIDS and carry implications for any health issue being tackled at community level (Campbell and Cornish 2010).

The expansion of a community discourse in the field of Global Mental Health has been driven largely by the Movement for Global Mental Health (MGMH) (see Patel and Prince 2010), whose main interest resides in addressing the gap between the proposed need for treatment and available services in LMICs. Their interest in communities has been linked to community approaches piloted during the first two decades of the AIDS response (Campbell and Burgess 2012) and the wider deinstitutionalisation of mental health services beginning in the 1960s and 1970s. Capacitating local communities to promote self-care through promoting volunteerism and training of lay community health workers has assumed the core of the community engagement framework within global mental health. The publication of a series of grand challenges for global mental health (Patel et al. 2011) confirmed the importance of communities to the movement with two ‘challenges’ explicitly naming ‘community’ as a locus of action:

1. Provide effective and affordable community-based care and rehabilitation.
2. Support community environments that promote physical and mental well-being throughout life.

Community-based care and rehabilitation have formed the focus of multiple studies and research to identify ‘cost-effective’ mental health interventions delivered by community volunteers and health professionals under the umbrella of ‘task-shifting’ approaches (Kakuma et al. 2011). In this model, community health workers are trained in basic treatment skills to act as appendages to over-burdened or non-existent health systems. Health volunteers are to act as trusted conduits, it is hoped, smoothing relations and the uptake of ideas among local individuals. The second point, promoting supportive community environments, speaks more directly to ideas of social change, and on efforts to ensure that communities (local environments) are places where positive mental health can be maintained.

Theoretically, community-based approaches allow for attention to a wider range of determinants of mental ill health and related responses, which could contribute positively to addressing both of the above ‘grand’ challenges facing the movement. However, given issues faced with implementing community approaches in other health settings (Campbell 2003), how do we develop approaches to ‘community’ mental health in a global context?

Defining ‘Community’

In order to trace the complexities facing ‘community mental health’, one must acknowledge limitations of the term ‘community’ itself. Traditional social science debates about the concept cut across multiple fields: making the term inherently plural, fluid, and malleable, with practical, symbolic, and rhetorical weight (Howarth et al. 2015).

Community typically conjures the image of a coherent (and often positive) grouping of individuals, united by a common factor that shapes the identity of each member in some way. The term describes groups of individuals united by characteristics such as location, shared practices and values (i.e. a profession), common experiences (racism/exclusion), interest (i.e. a hobby), culture, religion, or physical characteristics, such as a health diagnosis (Howarth 2001). These categories can be organised into two broad camps—communities linked to tangible structures, such as spatial dimensions, and those linked to 'symbolic' and intangible dimensions, such as identity or cultural norms.

Community ultimately gains meaning through the value the categorical label holds to someone's everyday survival (Cohen 1985). In this sense, structural dimensions of community, such as areas of space, are equally important as symbolic dimensions and are often inseparable. For example, participation in cultural celebrations, such as birth celebrations, cannot be divorced from the structural dimensions of spatial communities where a cultural practice is lived. The availability of services, quality of housing, and economic opportunities available within a community exert forces on the ability to participate in a cultural celebration, with meaningful impacts on one's life.

Individuals often hold memberships to multiple 'communities' at any given time and can accept or reject membership based on the importance of a community identity (Howarth 2001; Jovchelovitch 2007). Thus, we could better think of people as 'living' community—through their actions, relationships, and other forms of social participation—a perspective that is often absent from community health approaches. In fact, it is perhaps more useful to view any single community as an interactive space—one where the realities of any one community blend into and influence the reality and outcomes of others (Burgess 2013b).

However, the fluidity of the term also makes it open to co-option, particularly among political platforms, who invoke the term to serve different and sometimes contradictory ideals. For example, successive British governments' use of the concept anchors to the belief that 'communities' are self-sustaining, able to improve themselves in spaces outside of state support (Fremeaux 2005). Conversely, the term is also linked to highlighting the plight of 'at-risk' and 'excluded' communities who must be targeted for special support and resources in order to tackle inequality (Allen et al. 2014).

In light of such controversies, engagement with community will involve attention to the making and shaping of meaning, which is in turn influenced by social forces and power relations between groups. What are the implications of this 'plurality' for community interventions that seek to address mental ill health?

Addressing Community Mental Health: A Moving Target?

The classical position assumed in community mental health across low- and high-resource settings foregrounds community of place. In North America, this is driven by the legacy of deinstitutionalisation with group homes, nursing homes, and other neighbourhood settings where patient care often occurs (Knapp et al. 2011). Community case managers often coordinate multiple health and social care services for mental health clients with complex needs, often without equal attention to social challenges such as poverty, unemployment, criminalisation, and violence (Kleinman 1988). Individuals often oscillate between acute hospital settings and incarceration, while many struggle with homelessness or settings that exacerbate experiences of mental distress, rather than resolve them (Weinstein et al. 2013).

In African and other low-income country settings, resource limitations and a lack of mental health policies have limited the availability of community mental health care services. Trials of community-based services in some countries date back to the 1960s and 1970s, where, in line with deinstitutionalisation movements elsewhere, emphasis was placed on treating individuals within community spaces. While many countries continue to over-rely on institutional settings, there has been a shift towards the provision of mental health within primary care on the continent (Hanlon et al. 2010). Current community approaches include a range of interventions, such as integrated primary mental health care, which links mental health services to existing primary care clinics and programmes and is increasingly popular in LMICs (Petersen et al. 2009).

From a pragmatic position, communities bounded by space are an inescapable dimension for health services. Across districts, provinces, or neighbourhoods, health practitioners are allocated based on population levels. As such, attention to communities of ‘place’ in itself is not limiting, as place-driven realities are known to exert boundaries on the possible realities for social outcomes (Howarth, Foster and Dorrer 2004). For example, poverty, violence, and unemployment contribute to mental health outcomes, making the achievement of well-being more or less likely in settings shaped by such factors. Ultimately, it is the prioritisation of community as place over other forms of community that emerges as problematic (Campbell and Cornish 2010).

Increasingly, mental health supports have attempted to engage with broader community issues of culture, power, knowledge, and identity, which are key psychosocial determinants of mental well-being (Keyes 1998; Burgess and Campbell 2014). For example, a 2012 special issue on community mental health in Australia acknowledged the importance of viewing community at the level of space (environmental infrastructure), place (socio-historical dimensions of community), and people (attention to the skills and capabilities of individuals) to the promotion of mental health in low-income communities (Rose and Thompson 2012). Furthermore, community psychology approaches aim to promote justice and social change in communities through attending to the interplay between symbolic (i.e. identity) and structural (i.e. poverty, systems of governance) aspects of community and their related impacts on health within the space of interventions (Nelson and Prilleltensky 2010).

However, current WHO and MGMH discourses driving research and action frameworks for mental health practice tend to emphasise community engagement in relation to the pragmatics of bio-psychosocial services, assuming community homogeneity in the process of prioritising spatial dimensions above other issues (Campbell and Burgess 2012; Patel and Prince 2010; Summerfield 2008). For example, a recent study exploring the foundations for integrated mental health care in five low-income countries (Hanlon et al. 2014) asserts the importance of 'community' interventions such as adherence support, screening, and community-based psychosocial prevention. While the authors also reference the importance of multi-sectorial collaboration to tackle broader social issues such as housing, this is linked to individual plans for recovery rather than attention to tackling wider social environments that contribute to mental distress in equally significant ways (Fullagar and O'Brien 2014).

The success of Global Mental Health approaches would likely be accelerated by eschewing the current emphasis on the pragmatics of services in favour of promoting more meaningful engagement with communities (Campbell and Burgess 2012; Kirmayer and Pedersen 2014; Swartz 2012). To achieve this, frameworks that integrate attention to short-term treatment and recovery issues with wider social determinants of mental health are needed.

Community Mental Health Competencies: A Flexible Framework for Community Mental Health

Recent work by the first author of this chapter (Burgess 2012; Campbell and Burgess 2012; Burgess 2013b; Burgess 2014) articulates the value of critical community psychology frameworks in grappling with the complex nature of community and a wider range of socio-structural determinants of mental health. The *community mental health competency framework* (Burgess 2012; Campbell and Burgess 2012) begins with a reconceptualization of 'community' for mental health. In this framework, mental health services are positioned as the meeting place of multiple communities, which are often linked to varied approaches to mental ill health (Kleinman 1988; Swartz 1998). These symbolic and relational communities are then viewed within the context of a shared community of place, in order to account for the impacts of social and structural factors on service outcomes. This enables tangible impacts of poverty, violence, unemployment, and a range of other social challenges that characterise many communities around the world to be seen as active factors that shape the lived experience and understandings of community members (Summerfield 2008, 2012). This is particularly important given that LMIC settings are often marked by such characteristics.

Another important feature of the community mental health competency approach is the emphasis on partnerships. Bourdieu (1986) argues that attention to different forms of social capital is critical to health, as access to social, cultural, and economic capital may open pathways to resources that may mediate health risk. Partnerships are viewed as routes to increasing access to these forms of capital. Similarly, Putnam (2000) suggests that social capital provides ties within communities that enable access to necessary structural and symbolic resources. Bridging social capital is one example of such partnerships, which build ties to agents outside of a particular community with access to alternative and needed resources. Within the proposed framework, programmes are viewed as opportunities to strengthen existing partnerships, or establish new ones, with communities, with a view to establishing links to resources beyond those that already exist. Partnership building is supported through quality communication between actors in line with Habermas's (1984) concept of communicative action—where both groups are engaged in a communicative encounter that drives towards both actors being heard. In many instances, promoting such communicative encounters requires attention to the development of safe spaces, where traditionally excluded voices have the opportunity to be heard (Fraser 1990).

In order to continually foreground structural community drivers of distress, the framework suggests that programmes should also seek to foster resources that enable communities to identify and engage with issues they deem problematic, which are often shaped by economic and political processes beyond local control (Campbell et al. 2007). Rooted in Freirean notions of engagement that promote critical awareness of oppressive social relations (Freire 1973), the form of engagement suggested by this approach should occur alongside addressing mental health needs and involve participation by members from various subgroups of a community (i.e. treatment groups, families, members from the wider community, practitioners). All subgroups should be viewed as agents and partners with important knowledge that contributes to the promotion of well-being. By taking these factors into account during initial planning stages, interventions are designed with the foundations for expanding the knowledge of groups and increasing local strength and capacity for change.

Table 11.1 Four community mental health competencies (Burgess 2012, 2013b; Campbell and Burgess 2012)

Knowledge	• Enhances the ability of communities to identify and refer serious cases of mental ill health and respond to others in a culturally appropriate manner • Supports the acceptance of cultural and social narratives among professionals
Recognition of individual- and group-based skills, and solidarity to tackle the issue	• Helps communities develop or expand on existing skills that can contribute towards addressing mental ill health • Mutual recognition of the validity of contributions from both professionals and lay individuals
Safe social spaces and dialogue	• Promotes dialogue between outside mental health professionals, local mental health service sectors, and target communities • Communities develop better understandings of the links between social environments, symbolic issues, and mental health outcomes (critical consciousness) within safe social spaces
Partnerships for action	• Supports opportunities for individuals and groups to exercise agency to improve the conditions that they feel impact their mental health • Promotes linkages to external agents with access to material and symbolic resources where appropriate • Ensures sensitivity to issues of power that influence who acts around mental health

The competencies for community mental health introduced in Table 11.1 emerged through research into community mental health services in South Africa conducted in 2008–2011 by the first author (see Burgess 2012, 2013b). Each of the four principles was identified as psychosocial resources key to the promotion of spaces where mental health issues can be addressed in locally sensitive and relevant ways, alongside efforts to tackle wider determinants of distress.

The remainder of this chapter is organised around two case studies, each exploring how attention to community mental health competencies responds to mental ill health in locally relevant ways. The first case study explores the dimension of partnerships and knowledge through a discussion of the inclusion of traditional healers in mental health services in a rural community mental health setting in South Africa. The second case study explores a partnership around a community mental health programme in western Uttar Pradesh, India, and highlights the influence of key socio-structural challenges on attempts to establish competencies related to knowledge and safe social spaces. Cases draw on data in different ways—the first draws on analysis of a cluster of interviews with traditional healers, and the second on evaluation research and focus groups about the community mental health programme.

Traditional Healers in South Africa: Knowledge Without Power

Background

Though technically classified as a 'middle-income country', health services in South Africa are characterised by polarities, particularly within mental health services (Lund et al. 2010). Much of the country continues to struggle for access to basic amenities, including electricity and running water, and is categorised as one of the most unequal in the world (Coovadia et al. 2009).

The rural community at the heart of this case study is located in the province of KwaZulu-Natal, just south of the Mozambique border. The province is one of the most underserved in terms of mental health services, marked by high levels of mental illness risk factors including a large proportion of individuals living below the poverty line (Burns 2010). It is marked by high rates of HIV/AIDS (Welz et al. 2007) and high levels of unemployment (Statistics South Africa 2006). Mental health services are delivered using a primary care approach (Department of Health, KwaZulu-Natal 2003) within a district health model. The catchment area of focus is a rural sub-district with a population of just over 106,000 individuals (Department of Health, KwaZulu-Natal 2010).

Flows of power and resources traverse multiple tiers of care. The 'community' is found at the base of the pyramid, who play a monitoring role, responsible for referring individuals up through the medical sectors (Department of Health, KwaZulu-Natal 2003, p 11). The 'community' is comprised of multiple actors: NGOs, police officers, social workers, teachers, community-based organisations, community leaders, and spiritual and traditional healers. A larger case study completed by the first author featured a brief ethnographic study of this service model (See Burgess 2013b for details). Semi-structured interviews with actors linked to the various communities engaged with mental health services in the subdistrict were conducted. The subsequent discussion refers to data collected during life history interviews with traditional and spiritual healers, exploring their contributions to 'community' mental health services in the area.

South African healing traditions are linked to notions of spirituality and reverence to ancestors (Berg 2003; Parle 2007). The role of the healer is to help restore balance between the self and various aspects of the individual's social world. In KwaZulu-Natal, illnesses are divided into natural conditions (linked to biomedical concerns) and those linked to ancestral discord. Typically, natural conditions are initially treated by herbalists (Izinyangas).

Long-term illnesses are believed to have roots in ancestral disharmony, and as such, for chronic illnesses, such as mental health conditions, an Izangoma (spiritual healer) is often sought for support (Flint 2008; Urbasch 2002).

In this study, despite healers' description of mental illnesses along the traditional lines outlined above, their discussions also acknowledged that there were social and relational issues at the heart of distress. Two healers noted that in contemporary society mental distress was linked to causes that they didn't understand fully. As noted by one healer:

> During ancestral times it (mental illness) was there and it was caused by bewitchment—enemies bewitching people … But today we don't know because a lot of sicknesses today can cause mental illness. (Izangoma, Female 1)

A long-standing body of research presents a discourse that positions traditional healers' involvement in mental health services as largely problematic. For example, Sorsdahl et al.'s (2010) recent study cites a high number of deaths linked to traditional healers and notes the problematic use of potentially lethal combination of herbal medicines and toxic additives such as methane.

Healers' interviews included descriptions of differential diagnosis process. They clearly parsed out differences in which those suffering from issues linked to more common mental disorders such as poverty and familial discord were supported versus those with more severe conditions. Approaches to common mental health disorders did not include any of the more potentially harmful interventions that are critiqued by biomedical practitioners. As one healer described:

> Patients will often talk about things that are not well at home … like if someone can't sleep because they are having nightmares, or they don't have a job … this can all be caused by evil spirits. I take them outside for baths to cleanse away the evil spirits. (Izangoma, Male 2)

Other treatment approaches included wrapping patients in 'blessed' pieces of cloth, as well as the process of 'throwing the bones' to explain the meaning behind clients' experiences.

Despite plans to include traditional healers as partners within the delivery of mental health services from as early as 2003, in practice this process has been fraught with difficulty given conflicting knowledge systems that drive traditional and formal health systems. This has often been linked to the negative attitudes held by many biomedical practitioners towards the methods and practices of healers (Urbasch 2000). Despite current policy stipulations that call for partnerships with healers (Department of South Africa 2013), engagement between the two groups remains limited and is shaped by continuing imbalances in power between the two groups. Healers in this study spoke of their experiences in partnering with formal health sectors, usually nurses, for training sessions. None of these engagements were for mental health (all had attended training on HIV/AIDS and TB). Their accounts noted unbalanced relationships with health services, attending sessions where they were told to explain how they made their medicines, with promises of further meetings with guidance on new treatments for their patients that never materialised. As noted by one healer:

> We registered (with the doctors) and they told us that we will meet and talk about cases and treatment. We learned new things but they don't learn things from us—they asked us to cook our traditional medicine, and to tell them how we treat patients—but nothing has happened since then, because they take us for granted. We send patients to them when we cannot help them, but they don't send patients to us. (Izangoma, Male 1)

Accounts from healers in this community highlight that the main aim of the partnership remains—the use of traditional healers as extensions of the medical system—with little desire to engage in mutual frames of understanding and action. Healers' participation, and thus the success of these partnerships, is influenced by dimensions of power and recognition (Burgess 2014). When biomedical systems are criticised by community members as 'brief or ineffective' by patients and family members, traditional healers can provide a seemingly positive alternative (Read et al. 2009). This means that in many cases, pluralism in service use is the prevailing norm—with patients utilising both traditional and biomedical services in tandem (Swartz 1998) or sequentially (Read et al. 2009). Accounts from healers in this study highlight that where partnerships with the health sector threaten the power of healers, or are interpreted as disrespectful to healer's training and knowledge, traditional healers will be reluctant to engage at all—limiting the utility of partnerships for both healers and formal practitioners. The result is a missed opportunity to increase the availability of support to communities through capacitating local healers to build on their existing set of responses to distress, as well as the alienation of key routes to access within local communities.

The second case study presents an example of a combined partnership between communities and the formal health sector. The approach is informed by a rights-based framework, attention to community empowerment, and increasing access to biomedical services for people with severe mental distress.

Building Community Mental Health Competence in Western Uttar Pradesh: Successes and Challenges

Background

SHIFA, a community mental health project of the large non-profit faith-based organisation the Emmanuel Hospital Association (EHA) (www.eha-health.org), started in April 2012 in Sadoli-Kadim block (an administrative unit of around 150,000 people) in Saharanpur district, Uttar Pradesh (UP), at the upper reaches of the densely populated Gangetic plain. SHIFA is supported by an Australian community development funder, and had been supporting community health and development initiatives, including community organisation, reproductive and child health, and micro-credit savings groups in the Sadoli-Kadim area in the previous nine years. They had moved to focus on promoting mental health and disability rights after building relationships with multiple families affected by disability and mental illness who described complete lack of access to care and support (Varghese et al. 2015) and requested support from the project. Saharanpur is a relatively poor district with 3.5 million people (40% Muslim, 60% Hindu) and a literacy rate of 53%. Health indicators for the district are lower than national and UP state averages. Western UP has been a recent flashpoint for communal violence (Bhatt 2013; Times of India 2014).

While a District Mental Health Programme (DMHP) was launched in India in the 1980s, it has been imperfectly and incompletely implemented across the country (Jain and Jadhav 2009; Sarin and Jain 2013). In Saharanpur district, there are no mental health services provided by the government, no psychologists, and one private psychiatrist. The second author is linked to the project through her work as a mentor and technical advisor. The following discussion reports on data gathered through observational and support visits to the project, and interviews with people with mental distress and other community members.

At the start of the SHIFA project, the biggest areas of felt need described by the community were for support to caregivers, knowledge, skills in mental health, and access to care for people with mental distress. The community also described significant social exclusion and stigma for people with seizure disorders and mental distress.

The overall vision of the SHIFA project was to empower communities of Sadoli-Kadim block, in the universal promotion of mental health. This included strengthening the community voice to advocate for care and support through the formation of community-based disabled persons groups (DPGs), and increasing awareness and knowledge among 35 mental health volunteers

Table 11.2 Success Factors and Challenges in Building Community Mental Health Competencies in SHIFA Project, Uttar Pradesh

	Success factors	Challenges
Knowledge	Knowledge and awareness led to referral networks and normalised experiences (Petersen et al. 2012)	Lack of explicit training in conscientisation for project staff and community volunteers
	High commitment to training of community volunteers and peer educators (frequent trainings, curriculum, resource development with support from psychiatrist)	Lack of confidence/training/skills in leading community discussions using rights-based frameworks
Safe social spaces	MHVs and PEs representative of minorities in community enabled acceptance and participation of these groups including people with disabilities (less for people with mental distress)	Enduring social hierarchies and scant 'horizontal dialogue'(Freire 1973, Campbell and Jovchelovitch 2001)
	Care plan prioritised felt needs of client increasing their agency and participation in their own recovery	Frequently changing government functionaries and lack of will in district health officers to provide access to services for people with mental distress
Partnerships and collaborative actions	Fortnightly clinic provided platform for non-pharmacological and biomedical therapy, awareness, knowledge building, street theatre, and social interaction	Lack of historical precedents of communitisation Recent communal violence in the district discouraging loud voices seeking to bring change.

(MHVs) and 140 trained peer educators (PEs). Further objectives were to strengthen the public health system through community monitoring and to increase access to primary mental health care, using the framework of the United Nations Convention for Persons with Disabilities (CRPD) (United Nations 2008). After 15 months of project implementation, the SHIFA project started a fortnightly mental health clinic, led by the EHA psychiatrist and a primary care physician located nearby (Table 11.2).

Knowledge

Focus groups with community members held at the outset of the project identified that some people understood seizure and severe mental distress as being caused by an evil spirit or by 'black magic'. Other community members considered severe mental distress as a stress reaction to life events or as an illness. A total of 35 community MHVs were selected by their communities and worked in their respective panchayat (administrative unit of around 2000 people) with the aim to build awareness and knowledge about mental health in the community. A further 140 adolescent PEs were selected as the community members with most available time who could then train other adolescents and community members. All volunteers were trained in basic knowledge and skills for mental health promotion such as in rights-based approaches, stress management, and communication skills. The intervention was delivered through regular awareness and larger group meetings held in different communities by MHVs and PEs, and through smaller meetings with groups that focussed on skill and capacity building. There was a significant increase in biomedical mental health-related knowledge and skills, such as the ability to identify and differentiate common and severe mental distress, particularly among the 175 community volunteers. Caregivers reported increased skills in areas such as reflective listening and problem-solving. Peer educators reported increased confidence to speak out in schools and community gatherings, particularly in areas related to rights, health, and relationships. Increased knowledge seems likely to have led to an increase in the number of people seeking biomedical care. At the start of the project, to our knowledge, there were only a handful of community members accessing biomedical mental health services (all attending a private psychiatrist 70 km away in the district capital Saharanpur). By the end of March 2015, community volunteers and staff working with SHIFA had identified and provided social and psychological support, treatment or referral to 150 people with common mental distress, 70 people with severe mental distress, 35 people with a seizure disorders, and 13 people with intellectual disability (Kamal 2015). Around one-third of these people regularly attended the SHIFA primary mental care clinic held fortnightly. There were also reports of increased attendance for support with mental distress by local pharmacists, traditional healers, and local doctors. Workshops held by project staff with religious leaders, traditional healers, and local doctors focussed on building their knowledge and skills in active listening and encouraging referral of people with seizure disorders and severe mental disorders to the biomedical health clinic while their clients continued to also access their services.

Safe Social Spaces

While some dialogue and critical thinking about mental health occurred between MHVs and PEs, they themselves struggled to facilitate critical discussions in wider community settings. Stigma was a completely obstructive barrier to the inclusion of people with mental disorders in community-based DPGs. While ten DPGs were formed, they were fully comprised of people with physical or sensory deficits and people with both common and severe psychosocial disabilities were excluded.

SHIFA, however, did make some small gains to amplify safe social spaces for people with seizure disorders by facilitating open discussion among community members as well as providing access to medical care. A mother from one community reported that her child who had been socially ostracised by neighbours due to her frequent seizures became fully engaged in school and social life following medical treatment to manage her seizures.

Developing Partnerships

Some progress was made by community members working collaboratively and with outside groups to increase resources for mental health in their community. Through training and information, community members with both physical and psychosocial disabilities increased access to government entitlements. Two hundred and sixty-three people accessed disability certificates and 126 people started on the disability pension. Another example of an evolving partnership was the invitation to SHIFA to run their mental health clinic in the government community health centre.

Challenges

Despite successes in the above areas, the SHIFA project struggled to increase the availability of safe social spaces as opportunities for ‘critical thinking’. Four main factors impacted on this process in the following ways. First, a lack of confidence and skills in leading critical discussions within a rights-based framework led to an inability to support effective discussion groups at the project level. Despite EHA’s progression towards a rights-based framework since 2010, the majority of staff and community volunteers were not formally trained in a critical thinking framework.

Second, deeply embedded social hierarchies and divisions in Uttar Pradesh complicated wider community engagements. Social divisions were reflected in the recent Saharanpur district communal violence in July 2013 and January 2014 between religious groups. Government health officers, community health volunteers, and community members all had multiple discussions with the second author expressing prejudice and mistrust of members of religious traditions different to their own. Community members described divides of caste, socio-demographic status, and particularly religion as restricting collaborative initiatives.

Third, there were few historical precedents of successful community action that could serve as a foundation or collective memory for community members. There is a sparse history of community agency and action in any areas impacting quality of life in Saharanpur district. For example, there are almost no accounts of collaborative community action on overt failures of public services such as poor roads, teachers absenteeism in government schools, absence of essential drugs, and nutritional support for malnourished children at primary health clinics (Dreze and Sen 2013).

Finally, prevalent gendered hierarchies, exclusion of women, and exclusion of people of Muslim faith were evident and a stumbling block for wider community engagement. These groups respectively comprise 50% and 40% of the population but have disproportionately low representation in nearly all public positions and are widely recognised as excluded and disadvantaged (World Economic Forum 2009; Dreze and Sen 2013; Hassan 2013). In this prevailing masculine hegemony, women are overtly excluded from most decision-making and rarely make decisions on even household food expenditure. People with mental distress are also socially excluded, at times violently. Recent qualitative research in Sadoli-Kadim block and another western Uttar Pradesh district describes experiences of exclusion and inclusion for people with mental distress. It illustrates complicated communities where both social exclusion and inclusion are strong features of the lives of people with mental distress. Experiences of derision, disinheritance, and physical violence against people with mental distress were contrasted against experiences of belonging, opportunity for participation, and high levels of practical support from neighbours (Mathias et al. 2015).

Many of the successes of the first phase of SHIFA project suggest that strong community representation with both PEs and MHVs creates a strong foundation for expanding safe social spaces and partnerships. Opportunities for future growth reside in capacity building of community members and SHIFA staff to increase skills in facilitating critical thinking about wider social determinants at both organisational and community levels.

Discussion

Despite the renewed attention 'community' has garnered within the MGMH, the question of what communities need for the promotion of mental health and well-being is a long-standing concern in the fields of health promotion and community development. These case studies have highlighted the importance of complicating the term ‘community’ in global mental health approaches. In each case, we see that ‘community’ mental health services include a range of actors from traditional healers, to district level hospitals, to service users and members of a wider shared geographical community who contribute to the promotion of mental health.

Case studies have highlighted the importance of knowledge, community identity, and partnerships as key phenomena that may sway the success of community mental health interventions. Beyond this, the ongoing importance of attention to social determinants, partnerships with more powerful stakeholders, and collective action by communities to address the realities that impact their health remain as important areas for further engagement.

The SHIFA project made significant progress in increasing community knowledge about mental health issues and made some attempts to engage with pre-existing local knowledge about mental health. However, the project struggled to significantly increase safe social spaces and collaborative community action to develop partnerships. The Community Mental Health Competency framework offers possible routes forward from this impasse. A conscientisation process which acknowledges and engages with structures driving social exclusion, such as the prevailing gender order of hegemonic masculinity (Connell 2012), could potentially provide a route to bring excluded groups within wider community participation. For example, a recent study of effective community monitoring of health services in Maharashtra highlighted that development of critical thinking contributed to the development of safe spaces (Shukla et al. 2013), and could be applied similarly within the Sadoli-Kadim community to promote collective action.

Traditional healers in South Africa highlight the importance of attending to issues of knowledge and power in establishing key partnerships for the promotion of mental well-being. The views of traditional healers in this study illuminate a gap in current engagements with healers, particularly around valuing the knowledge held by this community, and a recognition of their expertise and ability to meaningfully contribute to care. Within global mental health, what counts as knowledge is often that which is produced by ‘science’, driven by calls for increased randomised controlled trials to determine next steps in treatment and care (Patel et al. 2011). This emphasis has been argued as problematic, a form of engagement that produces socially de-contextualised understandings of mental ill health, with limited attention to the impacts of cultural understandings of distress that exist within various communities (Summerfield 2008). Furthermore, such approaches have been criticised for their inability to grapple with the complexity of community realities that also shape services (Burgess 2016; Rifkin 2014; Pawson et al. 2005). This emphasis on production of rational scientific knowledge diverts attention from the value to be found within indigenous knowledge systems and reifies a binary between biomedicine and 'lay knowledge' within mental health. However, given the growing evidence of plurality of modalities of care for many users (Halliburton 2004), attention to how the knowledge held by groups like healers can better contribute to treatment is critical for community service models to be truly representative of community needs.

Both case studies shed light on the importance of attending to structural realities imposed by communities of 'place' to improve community mental health. In South Africa, the history of segregation and limited power surrounding traditional healers is linked to the problematic insertion of this group of actors into the community mental health system as 'equals'. In India, the existing structures maintained exclusion for people with mental distress from DPGs and no group or person felt confident to address these.

The value of partnerships was reinforced by both case studies. Partnerships have been linked to positive health outcomes by many theorists. For example, Campbell and Burgess (2012) argue that the MGMH's network of global partners with access to economic (funding) and political (policy leverage) forms of capital creates potential nodes for local community actors to leverage efforts to transform their local environments. Some positive gains have been witnessed in these areas, as seen for example with the Zambian mental health service user organisations who through links to the MGMH movement have been able to successfully lobby the national government to repeal outdated legislation (WHO 2010). However, there are fewer examples of how everyday community members are able to leverage and participate in global networks, with genuine engagements between local and global actors rarely seen.

Through exploring dimensions of a community mental health competency approach, the importance of promoting 'receptive social environments' for mental health emerges. In the case of the SHIFA case study, the need to target broader gender-driven norms to ensure equal participation in the use of knowledge is one example of this need. In South Africa, negative views among biomedical practitioners towards traditional healers limit the establishment of a receptive space. Receptive social environments in service spaces could be facilitated through attention to Woolcock's (1998) notions of 'linking' social capital, defined as partnerships that utilise brokers able to move between local community and external resources. Brokers effectively speak both 'languages' to facilitate the transfer of resources to local levels, by moving across multiple spheres, helping to translate key messages between community members who have shared interests (Cornish et al. 2012). This approach could permit the development of more meaningful partnerships between traditional healers and mental health services in South Africa by increasing trust and understanding between these groups.

Conclusion

Despite the complexities of implementing participation, dialogue, and critical consciousness, the relevance of a framework to guide community mental health approaches in the contexts of a global movement for mental health remains. Each case study highlights a different way of viewing community—a collection of partnerships engaged in a shared activity of developing a service, and as a specific group of individuals (healers) who need to be engaged in order to promote better services in a community of place. In each case, we see that through exploring the presence or absence of certain competencies, engagements and activates in varied communities are either helped or hindered. We also see the need for thinking about routes to accessing power—something that is enabled through links to wider groups and agents for action.

As asserted by Campbell et al. (2012b), global partnerships for health are not to be fully discounted, as they provide communities with gateway access to much needed resources. For example, providing countries such as South Africa with a solid platform to advocate with national governments for increasing budgetary allocations and services for mental health to address what is an undeniable level of need. However, these relationships have also been critiqued for promoting representations of mental health that remain at odds with local understandings and experiences of distress (Campbell et al. 2012b; Seckinelgin 2006) and often solidify top-down flows of power and resources that may potentially only further marginalise communities who struggle to manage socially disparate contexts (Aveling 2010). The promotion of community competencies implies an acceptance of the positive potential of such partnerships: their proxy for access to resources and empowerment. If Global Mental Health programmes were designed with the view of communities as active agents, then opportunities for engagement that drive community visions of mental well-being forward would be at the heart of efforts. Such an approach ultimately transfers decision-making power about definitions and responses to mental ill health away from high-income countries and to the hands of communities themselves. Whether the global movement sees such efforts as a fruitful way forward remains to be seen, but regardless, may provide our best hope for truly achieving mental health for all, in whatever iteration that may take.

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Three Challenges to a Life Course Approach in Global Mental Health: Epistemic Violence, Temporality and Forced Migration

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The World Health Organization (WHO) Mental Health Action Plan 2013–2020 highlights the centrality of a life course approach in Global Mental Health (GMH) (WHO 2013, p. 10). Consistent with this perspective, the GMH movement views many mental, neurological and substance use (MNS) disorders as either beginning or manifesting in early life (Collins et al. 2011). In order to address 'grand challenges of global mental health', research and interventions are targeted at people in all parts of the globe and across the lifespan. These range from mental health programmes in schools to a range of therapeutic interventions for younger and older adults. Preventative measures targeted at children and adolescents are viewed as having long-term benefits in reducing the economic and social 'burden' of mental health problems in later years. The Movement for Global Mental Health (MGMH) has set itself ambitious goals and takes its inspiration from 'HIV movements that have successfully mobilized significant global resources for the care of people living with HIV/AIDS in LMICs (lower and middle income countries)' (Patel et al. 2011, p. 88). These goals include the development of research and evaluation to establish effective treatments, the challenging of human rights abuses of people with mental health problems,

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the introduction of innovative therapeutic interventions across LMICs and the training of a workforce to deliver these interventions.

The focus on a ‘life course’ approach presents further specific challenges in terms of both research and practice, not least because of the difficulty in establishing the extent to which early interventions have had positive impacts on mental health in later years. One aspect of this challenge is the introduction of ‘mental health literacy’, defined by Jorm (2000) as ‘knowledge and beliefs about mental disorders which aid their recognition, management and prevention’ (p. 396). Of particular concern here is the introduction of such ‘literacy’ to populations unfamiliar with psychiatric and psychological terminology, including those who, for example, may not have thought of problems such as depression or anxiety as ‘illnesses’ requiring cures. Following Spivak, this may be referred to as the challenge of ‘culture and epistemic violence’ in recognition of the potential impact of introducing a new system of categories and meaning into populations (Spivak 1988). The ‘violence’ here relates to the potential effect of subjugating forms of indigenous knowledge, seen in recurring patterns where ‘a whole set of knowledges … have been disqualified as inadequate to their task or insufficiently elaborated’ (Foucault 1980, p. 82).

A second challenge relates to issues of temporality and the life course and considers directly questions of how time is conceptualized within intervention and research programmes. These may include the superimposition of normative developmental trajectories that disrupt culturally meaningful understandings of life stages and rites of passage. A third challenge emerges from the application of life course approaches to populations on the move at a time of unprecedented human movement in what has been characterized as the age of migration (Castles et al. 2003). The scale and dynamics of contemporary migration destabilize views of the life course as rooted in a particular cultural milieu. Indeed, the complexities of contemporary migratory experiences suggest that viewing the life course even in terms of a mediation between two cultures may be inadequate. Migrants, often children and young people, for example, may have experience of a range of cultures and have migratory trajectories often involving crossing thousands of miles. Their explanations for migration are often clearly rooted in narratives of flight from persecution in their home countries, and their sense of a life course involves a wide range of cultural influences. Moreover, the life course may be reflected on and articulated within the context of restrictive immigration processes whereby migrant ‘stories’ are told in institutional contexts where particular aspects aid legitimacy while others do not (Beneduce 2015).

Introduction: GMH and the Life Course

A life course approach to mental health is emphasized by the WHO as central to addressing the challenges of GMH. According to training guidance offered by the WHO, this approach 'emphasizes a temporal and social perspective; looking back across an individual's or a cohort's life experiences or across generations for clues to current patterns of health and disease, whilst recognising that both past and present experiences are shaped by the wider social, economic and cultural context' (WHO 2000, p. 4). Thus, part of the orientation towards a life course approach involves emphasis on supporting the health and well-being of children, as good mental and physical health in childhood is seen as preventing problems in adulthood and old age.

A life course approach is not only central to work on mental health but is also influential in the development of holistic models of well-being, such as proposed by the economist Richard Layard. These highlight a multilevel approach that includes childhood and early life influences and the importance of a range of 'adult outcomes' including economic factors such as income, employment and educational qualifications, social factors such as family status and criminality, and 'personal' individual level factors such as physical and emotional health (Layard et al. 2014, p. 721). Here, the life course and well-being are viewed as the product of interaction between individuals and 'the institutions in which they live' (ibid., p. 733), be they children's experiences in schools or adults' experiences in work environments. Within public health, the life course approach is viewed within a 'socio-ecological' framework and based on longitudinal research looking at 'exposure' to risk/protective factors ('social determinants') at individual, social and environmental levels over time (Ben-Shlomo and Kuh 2002). These result in specific health 'outcomes', for example, in terms of morbidity and mortality. As noted below, the life course includes principles of 'latency effects' in terms of the time lag between exposure to risk factors and outcomes, and the identification of particular critical periods in relation to the timing of exposure and the accumulation of risk factors.

In GMH, a life course approach is viewed as of central importance as testified by its ubiquity in policy formulations and practice guidelines. Before considering the centrality of this approach, it is important to contextualize it within the wider movement towards GMH. In an important contribution, Patel and Saxena (2014) advocate strongly for a global approach to mental health through pointing to the human rights abuses and barriers in accessing evidence-based treatments that may be experienced by those with mental health problems. Writing in the *New England Journal of Medicine*, they give the example of a man with mental health problems in northeastern Ghana who was bound to a log in his home village because his family could not afford $17 for antipsychotic medication. The authors proceed to place this case within a wider global context in which more than 10% of the world's population (some 700 million) is affected by one of a range of mental disorders and where there is widespread abuse of people with mental health problems (2014, p. 498).

According to Patel and Saxena, 'at the heart of these injustices there is a lack of access to evidence-based treatment and care' (2014, p. 499). The central thrust of the paper and of the GMH movement generally is towards increasing the availability of a range of treatments that are seen as having scientific validity, in the name of redressing inequality in access to 'evidence-based' treatment. In some ways, this orientation echoes Paul Farmer's powerful critique of the 'structural violence' that denies populations the right to adequate health care and medicines, resulting in millions of unnecessary deaths and debilitating conditions around the world (Farmer 1996). However, whereas Farmer's critical gaze is directed at powerful global interests in the form of multinationals and corrupt governments and incorporates calls for widespread political change, the focus of GMH is generally less overtly political and rests on seeking resources for GMH through argument and persuasion highlighting the economic 'burden' of mental health problems. The emphasis is on increasing access to individual treatments such as medication or therapy rather than on broader social or political determinants. Consistent with this approach, an emphasis on the life course underpins formulations of the 'grand challenges' of GMH. Collins et al., writing in *Nature*, advocate an orientation that recognizes that MNS disorders 'either begin or manifest in early life and is equally attentive to risk factors and disorders affecting children and the elderly' (2011, p. 28).

In seeking to address the injustices inflicted on those with mental health problems, advocates of GMH have highlighted the importance of responding to this burden though a series of policy actions, a central pillar of which is a life course approach that emphasizes the importance of identifying and treating mental disorders early, 'for example, by delivering school based interventions for childhood mental disorders' (ibid., p. 29). Goal A of the top 25 challenges for GMH aims at identification of 'modifiable social and biological risk factors across the life course' including understanding 'the impact of poverty, violence, war, migration and disaster'. Salient research questions here include, 'What is the relationship between early foetal and child development and the onset of MNS disorders?' and 'What role does social context play in the persistence of MNS disorders throughout life?' A challenge here is to develop a programme of research and clinical intervention that identifies salient biographical experiences and their intersections with environmental factors.

While the drive and ambition underpinning GMH has resulted in an impressive range of research projects and therapeutic interventions, there are very significant, and interrelated, challenges inherent in adopting a life course approach to GMH. As noted above, one of these may be characterized as the challenge of culture and epistemic violence. By this, I refer to problems that may be inherent in a range of GMH interventions such as the widespread introduction of mental health literacy whereby culturally meaningful modes of interpreting human conditions of suffering and distress are displaced by new 'regimes of truth', introducing new lexicons and professionalized roles and interventions.

Culture and Epistemic Violence

Advocates for GMH argue that it is important not to adopt a 'one-size-fits-all' approach and that services should be sensitive to national contexts and cultures (Patel and Saxena 2014, p. 500). However, there has been significant debate regarding whether GMH is sufficiently engaged with salient structural and cultural factors shaping human development and mental well-being (Fernando 2012; Summerfield 2012). Specifically, a perspective in which mental health is viewed across the life course offers a range of particular challenges to GMH, including the development of interventions that address long-term biographical influences including experiences in childhood and the impact of family, community and the wider society on mental health, in widely divergent cultural contexts. The complexities of social and cultural influences on mental health include culturally influenced aetiological and therapeutic models and assumptions regarding the causes of human suffering and distress. Thus, community-based mental health work requires skilful and empathic engagement with perspectives in which clinical and professionalized approaches to mental health may be seen as inappropriate.

Some of the challenges caused by introducing 'mental health literacy' can be considered by reference to a celebrated paper on culture and depression. Obeyesekere has observed that, faced with a Western description of depression, a Sri Lankan may well conclude that, far from being mentally ill, the depressed person may be viewed as a good Buddhist (Obeyesekere 1985). In Buddhism, *dukkha*, translated as 'suffering' or 'unsatisfactoriness', is part of the human condition, and a prerequisite for liberation is recognition of the ubiquity of *dukkha* in human life. One could go further and say that a truly sane person is someone who recognizes the fundamental unsatisfactoriness of the human condition. It is instructive to reflect on what benefits may arise from teaching people that, contrary to their beliefs, they may be observing incidences of a clinical condition called 'depression', a form of mental illness and, moreover, that the condition may be best treated by medication, in the form of anti-depressive drugs or by therapeutic interventions designed to alter the depressive world view. It is somewhat ironic that recurring episodes of depression have now been shown to be treated effectively by mindfulness—a form of meditation derived from the Buddhist traditions, which is now available in the UK's National Health Service. This approach involves developing peaceful awareness of depressive thoughts rather than attempting to block or displace them.

Summerfield (2012) has alerted advocates of GMH to the hazards of introducing diagnostic approaches deriving from Western psychiatry into communities unfamiliar with them, as they may increase stigma and undermine traditional therapeutic measures. Coker has pointed to the complexities of stigma and the relationship of stigma to wider conceptualization of selfhood and society. She notes evidence from Sierra Leone demonstrating that eliminating stigma was achieved not by superimposing a set of Western concepts but more thorough engagement with 'meanings of stigma within the society and how medical treatment interacted with those meanings than with medical education or particulars of the treatment itself' (Coker 2005, p. 921). Moreover, as Coker notes, stigma towards mental illness in the West is far from unproblematic and its manifestation is the product of a particular historically constituted and individualizing world view. While substituting psychiatric diagnosis for lay beliefs may be presumed to reduce stigma, this may be far from the case. Non-Western societies may have responses to particular manifestations of psychiatric disturbance that were supportive, so long as the disturbance was seen in social rather than individualized terms. As Kirmayer notes, 'classifying problems as "psychiatric" may confer stigma and disqualify the moral autonomy and agency of the individual who is viewed as "mad"' (Kirmayer 2012, p. 99).

Summerfield further argues that a focus on mental health frequently recategorizes economic and political problems into individualized medical problems, thus undermining potential for social and political mobilization. Rather than seeing problems such as high suicide rates among Indian farmers as a product of economic disparities, GMH advocates instead present the suicides as a mental health crisis. Summerfield argues that it is 'striking how often published studies of non-Western populations refer to subjects' 'limited knowledge of mental disorders', their lack of 'mental health literacy', or the need to 'teach' health workers and the people they serve about mental health (Summerfield 2012, p. 252).

There is a fundamental disagreement between Summerfield's position and that of GMH advocates such as Vikram Patel. Patel believes passionately in the epistemic and therapeutic sovereignty of a range of Western psychological and psychiatric interventions that are euphemistically referred to in GMH literature as 'evidence-based interventions'. While Summerfield views introducing programmes to promote mental health literacy as evidence of a form of psychiatric imperialism, Patel regards such measures as central to promoting the mental health of populations. It is helpful to consider this polarization in the context of Kirmayer's observations on the condition of cross-cultural psychiatry.

The focus on practical concerns yields useful clinical observations and tools but remains cut off from contemporary anthropology and little concerned with self-reflective criticism or theory building. At the other pole, we find social scientists and other researchers devoted to advancing medical and psychiatric anthropology as a scholarly discipline. Unfortunately, at times, this scholarly work has seemed to be an exclusively critical enterprise that does not consider the exigencies of clinical practice and the legitimate efforts of patient and clinician to wrest something helpful from their encounter (Kirmayer 2006, p. 128).

In reflecting on Kirmayer's observation of an overriding focus on practical concerns and an insufficient engagement with anthropology, self-reflective criticism and theory building, it is instructive to consider Patel's recommendations on meeting the challenges of adolescent depression, an important aspect of a life course approach to GMH. He identifies the first challenge as the low demand for health care, which is 'influenced by the degree of acknowledgement of depression as a cause of suffering that is malleable to health interventions' (2013, p. 511). To address this, he argues, strategies to raise awareness, or mental health literacy, are critical. The second challenge resides in the low level of detection of depression in adolescents within health care settings. He suggests this could be best addressed through routine screening in primary care. The third challenge relates to the lack of access to evidence-based interventions. According to Patel, evidence indicates that the most effective interventions for adolescents are psychological treatments, consisting of low intensity counselling and structured treatments such as interpersonal therapy. As there is a paucity of skills necessary to deliver these treatments in most parts of the world, he recommends 'task-shifting of psychological treatments to nonprofessional providers, and of internet based self-guided psychological treatments' (2013, p. 512). This emphasis on the introduction of nonprofessional providers is a consistent theme in GMH and WHO initiatives, and one that aims to address deficits in mental health services particularly in LMICs. The final component emphasized by Patel is prevention and in this context 'encouraging results' are cited from school-based interventions offered by lay counsellors undertaken in India (Rajaraman et al. 2012; Balaji et al. 2011). It is notable that, although these school-based interventions are here referred to in the context of adolescent depression, the interventions did not show clear benefits for adolescent depression per se, but were shown to be beneficial more generally for emotional and behavioural well-being.

Despite difficulties in assessing the impact of school mental health programmes, they are seen as significant resources for the development and implementation of GMH programmes focussing on the life course. According to a 2014 review in the Lancet, 'schools can offer opportunities and classes within the school structure to improve and promote mental health, and a place to potentially prevent development of more serious mental disorders' (Fazel et al. 2014, p. 389). Improving school attendance rates since 2000, and the Millennium Development Goal of universal primary education, is contrasted with a paucity of mental health service provision in LMICs. In this context, schools are seen as potentially excellent places in which to address the 'mental health gap' between a high level of need and a perceived absence of appropriate services. Besides being potentially fruitful locations for introducing mental health programmes, children in LMICs are seen as having higher risk exposures and lower protective factors in relation to psychological difficulties. According to Fazel and her colleagues, these include 'an absence of caregivers, problems with physical health and nutritional status, and deficiencies in the psychosocial and educational environment. Additionally armed conflict and chronic poverty disproportionately affect children in LMICs' (ibid.). The review concluded that:

> apart from some data on prevention and treatment of PTSD, many child and adolescent disorders that could potentially be prevented or managed within the school context lack any evidence base. There remained significant research gaps including the relationship between mental health problems and educational trajectories and their interplay with poverty, physical health, family and cultural factors. (2014, p. 394)

This focus of the mental health interventions examined by Fazel was consistent with the Institute of Medicine (IOM) framework which 'differentiates between interventions that promote positive aspects of mental health and those that address prevention and treatment of mental disorders' (Fazel et al. 2014, p. 388). The IOM is explicit regarding the centrality of well-being in its concept of promotion, arguing that mental health promotion is characterized by a focus on well-being rather than prevention of illness and disorder (2009). In many of the programmes examined, a broad focus on positive aspects of mental health and well-being did appear to be potentially beneficial in terms of children's general social and emotional health. Here, well-being and promotion of mental health were enhanced through a focus on the overall school environment and life of the school, including the development of 'health promoting schools' in which 'a broad health education curriculum is supported by improvements in the physical and social environment of the school' (p. 390). There was evidence indicating the benefits of programmes aimed at mental health promotion that integrated the efforts of health and education sectors oriented towards improving life skills and resilience, and which offered children help in understanding 'general principles of wellbeing' (p. 392).

The success of these holistically oriented interventions contrasted with the inconsistent evidence of the effectiveness of targeted interventions to prevent and treat mental disorders. It is not however clear from the review whether the categorizations used in targeted interventions were culturally sensitive and offered an 'emic' approach that built on local knowledge and understandings of mental health rather than superimposing categories alien to the population. Gaithri Fernando (2012) has argued that GMH will be severely hampered in its development if it does not seek to incorporate emic perspectives on mental health. While it is hard to draw firm conclusions from Fazel et al.'s review, it may be argued that in instances where a lack of success was noted in school-based programmes that focus on those in defined clinical categories, this may be due to the epistemic violence involved in displacing and perhaps devaluing meaningful idioms for identifying and conveying suffering and distress. Here, 'epistemic violence' may be represented in the reduction of political and economic issues collectively impacting on the lives of children to perceived individual level psychological problems.

Moreover, targeted prevention and treatment interventions may be skewed towards emphasis on addressing risk factors at the expense of a more holistic approach that builds children's resilience. Fazel and colleagues have pointed to the paucity of studies that address children's resilience but note that present research shows that resilience is a complex biopsychosocial process, with determinants at 'individual, family, peer and community levels' (p. 389). Wachs also notes the complex interplay of individual and societal factors in promoting resilience adding that factors associated with risk and resilience may be interrelated. He cites the example of how low levels of maternal education may be a risk factor in cognitive development of offspring while higher levels of maternal education may promote cognitive development and resilience (2012, p. 153). Adopting an effective life course perspective on mental health necessarily involves examining this interrelationship between risk and resilience and temporal influences on their manifestation and development.

Temporality and the Life Course

As noted above, a significant challenge for GMH is addressing modifiable risk factors across the life course. Meeting this challenge necessarily requires a sophisticated understanding of the relationship between adverse events and experiences at one stage of a person's life and how these impact on later life. Recent research challenges simplistic notions of the way relations between life events and mental health may be temporally circumscribed. Pearlin, an early advocate of a life course approach, noted the importance of stress process theory that encompasses a broader perspective on time than that implied in stress/response models. In arguing for a life course approach, he said it was 'less a deliberate choice than an inescapable recognition that the complex relationships between the various components of the stress process are established over a considerable span of time. Stress that is rooted in social and experiential conditions typically cannot be fully understood as a happening, as in an immediate response to a stimulus' (Pearlin 2010). Within the context of formulations of the 'grand challenges' that are identified for GMH, there is recognition of the importance of exploring linkages between early experiences and effects later in life, without unpacking the complexities of these relationships. Collins and her colleagues link a life course approach to the importance of supporting the development of mental capital in early life. They argue that 'the cognitive and emotional resources that influence how well an individual is able to contribute to society and experience a high quality of life—could also mitigate the risk of disorders such as depression, substance-use disorders, bipolar disorder and dementia' (2011, p. 28). They argue that the realm of potential causation even embraces the prenatal period, through childhood and adolescence, adulthood and old age. All of these stages in life are highlighted as being of potential concern to GMH.

The ambitious scope of a GMH life course approach is impressive, but there is a need to carefully unpack what constitutes its theoretical, methodological and practical dimensions. There is substantial evidence to support the view that early years are particularly important in determining a longer-term mental health trajectory, and as noted above, there are programmes around the globe that are informed by this perspective offering interventions and support from a young age in an attempt to secure subsequent good mental health. For example, significant research evidence exists of the impact of socio-economic disadvantage on children's mental health outcomes. Research findings from the USA suggest low-income families are disproportionately affected by parental depression and substance use disorders and their parlous economic status contributes to poor parental emotional well-being, insufficient child directed attention and harsh, and intrusive and punitive parenting (Yates et al. 2003). Economically disadvantaged infants have been shown to be subject to less stable care giving patterns and daily routines (Halpern 1993).

However, the developmental models that underpin such programmes have been criticized as being unduly normative and ethnocentric, imposing what is essentially a Western model of child development across the globe. Specifically, the growth of academic perspectives on childhood as historically, socially and culturally contingent raises questions of the appropriateness of employing models generated in specific Western social and cultural milieus to populations in different parts of the globe. The problems inherent in rolling out a standardized Western view of the life course are highlighted in the influential work of sociologist Ken Plummer. Besides the findings of social scientists who have identified a range of social and economic factors impacting perceptions of the life course, Plummer contrasts what he terms 'objective' or scientific accounts of life stages, which track early childhood through phases of Oedipal traumas, mirror stages, attachment and on to the adult stages of loss, despair, trust, hope, wisdom etc.', with what he views as a potentially more fruitful approach focussed on 'tapping into some broad metaphorical images through which people come to develop their own sense of how their lives develop the narratives of life patterns' (Plummer 2001, p. 192). He suggests a range of narratives with contemporary currency in the West as having progressive global influence. One common form arguably present in articulations of the challenges of GMH is what Plumber identifies as the 'childhood fix narrative', which places central focus on the influence of experiences in early childhood. The narrative is 'told in a linear, sequential fashion which implies the life is a cumulative sequence of causes' (ibid., p. 193). Accordingly, Plummer views childhood experiences as being treated far too uncritically as determining factors that shape the adult world.

The introduction of a life course approach in GMH thus faces the challenge of avoiding a rigidly deterministic perspective that fails to engage with cultural influences on family life and child development. For example, theoretical models of infant attachment have been challenged by studies in different cultural contexts. As early as 1928, Margaret Mead in her seminal work *Coming of Age in Samoa* had challenged the ubiquity and normative value of Western notions of child development (Mead 2001). Gillian Mann has pointed out that, while implicit notions of the mother as the primary caregiver are true in certain contexts, 'in many societies childcare is a social enterprise in which children have multiple caretakers and experience exclusive maternal care only in the first few months of life' (Mann 2004, p. 10), raising challenges to the standard accounts of attachment theory (see also Hiltrud and Keller 2014). Mann notes that the substantial impact of cultural factors is not reflected adequately in much of the research in that culture is examined only as an independent variable that may affect child development but not 'a system of meanings that creates alternative pathways for social, emotional and cognitive development' (ibid.). Moreover, notions of universal developmental time are challenged by Bourdieu's studies of agriculture-based societies in North Africa. He analysed the interrelationship between agricultural production, the apprehension of temporal rhythms and the stages of life. He identified a 'social structuring of temporality' that 'fulfils a political function by symbolically manipulating age limits i.e. the boundaries that define age-groups, but also the limitations imposed on different ages. The mythico-ritual categories cut up the age continuum into discontinuous segments, constituted not biologically (like the physical signs of aging) but socially' (Bourdieu 1977, p. 165).

The contrasts and conflicts arising from the incorporation of Western developmental conceptions of the life course are demonstrated in studies of child soldiers. Shepler (2005), for example, points to the interplay between the developmental models offered though NGOs operating in the global south and localized conceptions of childhood and adulthood. She suggests that it may be counterproductive to apply strict global models of the division between childhood and adulthood, without taking into account local notions of appropriate generational roles, and that psychosocial interventions that fail to understand local notions are less likely to be effective. Rosen (2005) has also critiqued what he characterizes as the 'straight-18 position', which uses reaching the age of 18 years as an arbitrary cut-off between childhood and adulthood, with respect to constructions of childhood and related interventions of NGOs with child soldiers.

Besides the challenges that cultural complexity poses to the adoption of a life course approach in GMH, a further concern relates to engaging with different perspectives on time. Here, we are concerned not only with different cultural formulations, but with the incorporation of perspectives on the relationships between biographical and historical time. Stress process theory highlights the importance of social roles in putting people at greater or lesser risk from stressors which in turn increase the risk of mental distress and disorder. Stressors can be mediated through social and social-psychological resources. As noted above, Pearlin viewed a life course approach as essential to understanding the relationships between stress, mental health and resilience. As George (2014) has noted, such an approach requires more than an understanding of biographical time but must also examine historical time and the intersections between biography and history. She argues that a life course perspective rests on a set of core principles that focus on time, the intersections of life domains that are typically studied separately, and balancing structural determinism with human agency.

Specifically, the adoption of a life course approach within GMH requires engagement with specific dimensions of time that have a crucial bearing on mental health and mental health research. As mentioned above, these include length of exposure to risk factors, duration dependence, timing and critical periods, and turning points or milestones (George 2014). As George has noted, we have an understanding of the relation between risk factors and mental health, but this understanding pays insufficient attention to the duration of risk. For example, we know that lack of social support is linked to poor mental health but not the relationship between the duration of absence of social support and mental health outcomes. Likewise, exposure to traumatic events in childhood is linked to later mental health problems, but there is little knowledge of precise linkages between the longevity of traumatic events and their impact on mental health and the factors which might potentiate or moderate them in different cultures and contexts. In seeking to address the impact of early life experiences on adulthood and old age that are presented as central to meeting the challenges of GMH, it is therefore vital to develop theoretical and practical approaches that engage with complexities of time and mental health. These should address not only issues of duration but moderating influences over time and the ways in which accumulation of risk may affect outcomes. They may take into account, for example, of the way risks may be mitigated in some cultures through encouraging problem-solving initiatives on the part of children, which develop competencies over time and enable children to respond positively to some risks (Crivello and Boyden 2014).

Forced Migration, Mental Health and the Life Course

The third challenge identified here is that posed by migration. As Castles et al. (2003) have noted, we live in an 'age of migration' in which unprecedented numbers and diversity of peoples are on the move. The complexities of modern migration are enhanced by rapid modes of transportation, increased globalization, global flows of forced migrants owing to political instability, war and environmental degradation. At the time of writing, thousands of migrants are perishing at sea in the Mediterranean and in Southeast Asia. Population mobility presents particular challenges to adopting a life course approach in GMH. In this context, a life course is spread across numerous geographical locations. Institutional sites, such as schools and hospitals, seen as desirable places to introduce mental health programmes, are of little utility when children and young people are on the move (Watters 2007b). Continuities between childhood, adolescence, adulthood and old age may be disrupted and symbolically significant rites of passage thrown in disuse.

Despite these challenges, over the past three decades, there has been a remarkable growth in mental health programmes for migrant children and young people, particularly for those arriving in high-income countries as asylum seekers and refugees. These have been augmented by a wide range of research projects focusing on the mental health of asylum seeking and refugee children. Indeed, research projects on the mental health of refugee children are so common they amount to around 70% of the research literature and other aspects of refugee children's lives (e.g. education, legal status, accommodation and integration) are given proportionately little attention. An emphasis on refugees' mental health may be seen as consistent with a wider orientation towards depoliticizing refugees' experiences and with a lack of engagement with issues of structural violence in the GMH movement noted above. However, the political is present in mental health initiatives albeit in a circumscribed manner and focused on the impact of political factors in the premigratory context. Within many studies of refugee mental health, premigration exposure to violence is seen as strongly predictive of psychological disturbance and much focus has been given to what Eastmond has characterized as the 'refugee curve' whereby the condition of refugees is described in terms of cumulative traumatic experiences originating in countries of origin and compounded through the experiences of flight and reception in 'host' countries (Eastmond 1998). The 'refugee curve' narrative introduces a distinctive perspective on the life course whereby refugees' lives are analytically segmented into experiences prior to flight from home countries, experiences during flight and post-migration experiences. Initial preoccupation with the mental health implications in home countries and during flight has been balanced to some degree in the last 15 years by studies that acknowledge and examine the impact immigration policies and practices in countries of reception have on refugees' mental health (Silove et al. 2000; Watters 2007a).

Research in the field has moved from a polarizing debate over the motives behind, and appropriateness of, a preoccupation with the mental health of refugees towards investigation of the impact of mental health diagnosis on modes of legitimation of asylum seekers in countries of reception. Writing in 2001, Didier Fassin noted that while there had been a significant decrease in the number of people being allowed asylum in France on the grounds of political persecution, there had been a concomitant rise in the numbers receiving opportunities to remain for humanitarian reasons, most commonly associated with health, in particular mental ill health (Fassin 2001). Thus, being identified as having a mental health problem had become a mode of legitimation, albeit circumscribed, in that humanitarian status offered an opportunity to stay in the territory for a limited duration. One can see in this context, the emergence of a distinctive moral economy, whereby ideas of deservingness are not associated with a political body but with the sick body and mind. Dismissing the labelling of refugees as simply a tool of psychiatric imperialism (e.g. Summerfield 1999) does scant justice to the complex ways in which mental health diagnosis may offer modes of legitimation in receiving societies. As I have documented elsewhere (Watters 2001, 2007a), within interaction between mental health services and asylum seeking clients, there are discernable processes of strategic categorization.

The identification of mental health problems may constitute evidence of the impact of traumatic events in the asylum seeker's home country or, at least, provide support for a temporary stay on humanitarian grounds (Watters 2001, 2007a). More generally, the role of mental health diagnosis within the context of forced migration may be seen as militating against the holistic perspective envisaged in a life course approach. Forced migrants' status is often fragile with every prospect of being forcibly returned to their home countries. Mental health diagnosis is often generated in a highly charged environment in which the asylum seeker's status is precarious. Processes of strategic categorization may be oriented towards optimizing the chances of the asylum seeker's case having a positive outcome rather than towards developing a perspective aimed at interventions towards long-term mental health (Watters 2001). A further complicating factor may be the emphasis on age determination of asylum seekers claiming to be children within a ubiquitous culture of mistrust (Bhabha and Crock 2007).

The chances of offering a life course perspective on mental health will be severely circumscribed if receiving countries do not engage with asylum seekers' own accounts of their stage in life. Indeed, examination of mental health and the life course in the context of migration offers a useful insight into the complex and challenging environments in which biographical accounts of life course intersect and may be challenged in particular institutional contexts. These are often sites in which differing perspectives on the life course carry significant implications for access to services. An immigration officer's assessment of the age of an asylum seeker, for example, governed by a 'straight-18' position, may be pivotal in categorizing the person as an adult or a child with major consequences for the support she or he receives and the opportunities for remaining in the country. This in turn may determine the types of therapeutic programmes he or she may receive, with distinctive mental health initiatives for refugee children and adults governed by distinctive epistemologies of care (Watters 2007a).

These challenging environments are not, of course, confined to migratory contexts, and users' accounts of their life course are often challenged within a range of mental health contexts. The culture of disbelief that infuses responses to refugees is often present in community-based mental health care (Watters 2001). Here, a life course approach, far from being underpinned by mutual understandings of the causes, nature and treatment of mental health problems, may be generative of sites of encounter in which differing explanatory models are invoked.

Conclusion

The *MGMH* has set a range of ambitious goals, not least to address mental health needs across the life course. Such an approach has wide ranging implications for research and the development of interventions in LMIC. A particular challenge resides in what has been described here as epistemic violence, pointing to the rupture that may be created by the introduction of psychiatric categories and treatment modalities with contexts in which they may be alien. These could potentially undermine and diminish indigenous explanatory models and disempower local expertise. A helpful way forward may be consistent with the model proposed by Weerackody and Fernando (2008; Fernando and Weerackody 2009) based on their work with displaced populations in Sri Lanka. Rather than superimpose Western-derived categories on the population, they adopted an emic approach in which they investigated the broad area of well-being and generated and operationalized categories from the people themselves. By going beyond the parameters of the Western idea of mental health and introducing well-being as a particularly capacious concept, the researchers had opportunities to incorporate a wide range of categories the displaced populations felt was relevant to their lives and welfare (see the chapter by White and Eyber in this volume).

The challenge of addressing the relationship between mental health and time is also significant. This too invites consideration of approaches that engage with communities' own concepts of time and the life course, including critical rites of passage that may be embedded in the cultures of the people for whom research and services are being developed. Advocates of GMH are correct in emphasizing the importance of avoiding a 'one-size-fits-all' approach (Patel and Saxena 2014). However, significant work needs to be done to ensure interventions engage in the best possible way with local perceptions of time, development and the life course. The third challenge introduced here is of populations on the move in an age of migration and the implications of mobility for a life course approach to mental health. Much of the literature on GMH evokes relatively stable if economically disadvantaged contexts within LMICs. The challenge of migration is likely to grow in coming decades and with this growth the need for the development of forms of GMH that further embraces the challenge of mobility.

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13

Addressing Mental Health-related Stigma in a Global Context

Ross G. White, Padmavati Ramachandran, and Shuba Kumar

The *Mental Health Action Plan 2013–2020* (WHO 2013) states that 'because of stigmatization and discrimination, persons with mental disorders often have their human rights violated and many are denied economic, social and cultural rights, with restrictions on the rights to work and education, as well as reproductive rights and the right to the highest attainable standard of health' (p. 8). Indeed, the vision statement included in the document concludes that people experiencing mental health difficulties should be supported to 'participate fully in society and at work free from stigmatization and discrimination' (p. 32). The importance of tackling stigma linked to mental health difficulties was also highlighted in the Grand Challenges for Global Mental Health (Collins et al. 2011), which state that there is a need to '[d]evelop culturally informed methods to eliminate the stigma, discrimination and social exclusion of patients and families across cultural settings' (p. 29). In view of the compelling influence that stigma can exert on the lives of individuals experiencing mental health difficulties and their carers, this chapter reflects on how global mental health (GMH) initiatives might address this important issue.

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Over the course of the chapter, emphasis will be placed on defining different aspects of the experience of stigma and understanding particular aspects of the experience of mental health difficulties that predispose individuals to being stigmatized. Research evidence that highlights the scale of mental health-related stigma will be highlighted. The impact that stigma has on individuals and carers will be discussed, including detrimental impacts on help-seeking behaviour, interpersonal relationships and employment prospects, as well as the potential for the emotional impact of the experience of stigma to compound existing mental health difficulties. Finally, the chapter will reflect on campaigns that have been launched to reduce mental health-related stigma and the implications that the evaluation of these programmes has for GMH initiatives. A recurring theme throughout these topics is the limited amount of research that has been conducted in low- and middle-income countries (LMICs) relative to high-income countries (HICs).

Defining Stigma

Stigma has been described as the way in which societies relate to a person (or group of people) who is in some ways different or possesses certain attributes that the society considers to be discrediting (Sartorius 2007). Kurzban and Leary (2001) have suggested that 'the process of stigmatization revolves around the exclusion of particular individuals from certain types of social interaction' (p. 201). It is clear that throughout history and across diverse cultural settings, individuals experiencing mental difficulties have been stigmatized, suffering personal anguish and a loss of individual potential, with significant psychological and social consequences (Padmavati 2014). In a recent study that interviewed 1082 participants with a diagnosis of major depressive disorder recruited from 35 different countries across the world, Lasalvia et al. (2013) found that 79% of participants had experienced stigma or discrimination in at least one life domain. Nearly one-third of participants had been shunned by people due to their mental health problems, and 37% reported avoiding doing something important in their work or personal lives because of stigma or discrimination (ibid.). The authors concluded that discrimination linked to depression may serve to prevent people from participating actively in social settings and benefitting from efforts to enhance vocational integration.

In order to try to address the stigma that people with mental health difficulties experience, it is important to appreciate the multifaceted nature of the phenomenon that is *stigma*. According to Corrigan and Watson (2002), stigma can be subdivided into three separate components: beliefs (i.e. stereotypes), attitudes (i.e. prejudices) and behaviours (i.e. discrimination). Discrimination has been highlighted as the most highly observable manifestation of stigma (Major and O'Brien 2005). It is also possible to distinguish between different manifestations of stigma, including *self*-stigma, *experienced* stigma and *perceived* stigma. 'Self-stigma' has been defined as 'the product of internalisation of shame, blame, hopelessness, guilt and fear of discrimination' (Corrigan 1998). According to Phillips et al. (2002), the internalization of negative evaluations is the most damaging effect of stigma and discrimination. A study conducted by Brohan et al. (2010) investigating the experience of 1229 people with schizophrenia across Europe found that just over 40% of participants reported having either moderate or high levels of self-stigma. Koschorke et al. (2014) in one of the largest studies conducted in an LMIC setting (recruiting 282 individuals with schizophrenia and 282 caregivers in India) found that 79% of participants with schizophrenia reported self-stigma, and this was strongly related to impaired role function. 'Experienced stigma' refers to restrictions in participation and discrimination that is actually experienced (van Brakel et al. 2006). Finally, 'perceived stigma' relates to the extent that people with mental health difficulties believe most people hold negative attitudes towards them (Link 1987). Lai et al. (2001), in a study that recruited 72 outpatients diagnosed with schizophrenia in Singapore, determined that 51% of participants thought that colleagues and/or neighbours might avoid them if they knew of their mental health difficulties. In a study conducted in Nigeria that recruited 103 people with a major depressive disorder, Oshodi et al. (2013) found that anticipated discrimination was a major factor in people concealing their mental health difficulties from other people.

Why Are Mental Health Difficulties Associated with Stigma?

Sources of stigma and discrimination can stem from a wide variety of sources, for example, employers, community members, family members, mental health caregivers and friends/acquaintances (Wahl 1999; Dickerson et al. 2002; Thornicroft 2006). Beliefs about the behaviour of people with mental health difficulties being abnormal and dangerous have been highlighted as factors precipitating and perpetuating stigma associated with mental illness (Vahabzadeh et al. 2011). These beliefs can be widely held across particular communities. For example, in Nigeria, Gureje et al. (2005) found that 83% of participants stated that they would have been afraid to enter into conversation with a person experiencing mental health difficulties. Similarly, 83% of participants would have felt ashamed if a family member had been diagnosed with a mental disorder.

Research evidence relating to the subject of stigma has demonstrated particularly strong negative attitudes and discriminatory behaviours towards individuals experiencing complex mental health difficulties, for example, forms of psychosis, such as schizophrenia (Dickerson et al. 2002; Thornicroft et al. 2009; Hamilton et al. 2011). This may be linked to people with psychosis being perceived to be violent and unpredictable compared to individuals experiencing mental health difficulties (Henderson et al. 2012). *Social Labelling Theory* (Waxler 1974) provides a potential explanation for how psychiatric labels such as 'schizophrenia' can compound the level of distress that the person is experiencing. If the individual 'receives many messages that something is seriously wrong with his (or her) self; his (or her) self-perception and behaviour may conform to these messages and his illness may have a long duration' (Waxler 1974, p. 379).

The Role of Explanatory Models

It is recognized that the explanatory models proposed to account for the causes of mental health difficulties can contribute to the levels of stigma that people experience. In Chinese society, mental illness is regarded as being a 'punishment for an ancestor's misbehaviour or for the family's current misconduct' (Lin and Lin 1980, pp. 387–401). In the context of these beliefs about mental health difficulties being caused by sins committed by their ancestors (Mandarin: 'zu shien zui') and the associated moral 'defect' attributed to sufferers and their families, mental health difficulties are regarded as highly stigmatizing (Yang 2007). In India, supernatural causes are perceived as a major cause for schizophrenia (Verghese and Beig 1974; Jiloha and Kishore 1997), and these causal beliefs can contribute to the aura of fear and shame that surrounds mental illness and create a fertile environment for stigma to develop. Whereas traditional and/or religious beliefs may give rise to blame through attributing mental health difficulties to possession as a consequence of wrongdoing, this relationship is complex and is mitigated by other features of the cosmology, such as acceptance of the will of God or an understanding of mental disorder as a burden borne on behalf of others (e.g. Quinn and Knifton 2014; McGruder 2004).

Capturing how the experience of stigma can vary across time, geography and people, Campbell and Deacon (2006, p. 414) suggested that stigma is 'constantly mediated by the material, political, institutional and symbolic contexts.' In apparent support of cross-cultural variation in stigma, Krajewski et al. (2013), investigating the experience of self-stigma in six European countries, found that participants living in Croatia had significantly higher rates of self-stigma than individuals living in Israel, Malta, Romania and Sweden. Furthermore, whereas in Croatia, Lithuania and Malta, self-stigma was positively associated with perceived devaluation and discrimination, in Israel and Romania there was a negative correlation between these factors, and in Sweden there was no significant association at all. Further research investigating between-country and within-country variation in mental health–related stigma and the associations that exist with explanatory models is clearly merited.

A systematic review of literature conducted by Yang et al. (2014) identified 196 studies that investigated mental health–related stigma in non-Western European cultural groups. The findings indicated that a large proportion of the studies utilized stigma measures that had been adapted from existing assessment tools that had been developed in Western Europe, and that only 2% of studies had employed stigma measures that had been specifically developed for non-Western European cultural groups. The review highlighted the need for anti-stigma campaigns aimed at particular cultural groups to be sensitive to the different types of qualities/capacities that these groups consider to be intrinsic to notions of 'personhood.' The review found that for Asian cultural groups 'preserving lineage' is an important consideration for personhood that should be considered when investigating mental health-related stigma in these groups. For Latino-American groups, battling to prevail in the face of difficulties and availing of immigration openings were highlighted as important considerations. Whereas for African American groups living in a context of past and present discrimination, it was found that a strong affiliation to religious institutions appeared to be a 'what matters most' factor for understanding how stigma can arise when mental health difficulties impact on individuals' capacities to maintain involvement with the church.

The Association Between Biomedical Explanations of Mental Illness and Stigma

Over the last 50 years, allopathic (i.e. biomedical) explanations of mental health difficulties have been predominant in the West. Some commentators have claimed that belief in biomedical causes is associated with comparatively low levels of stigma and discrimination (Link et al. 1999; Corrigan 2003). On the other hand, it has been suggested that biomedical causal explanations of mental health difficulties and diagnostic labelling by the general public have been associated with increased fear, prejudice and desire for distance directed at individuals with mental health difficulties (Read et al. 2006; Angermeyer et al. 2011). Angermeyer et al. (2013) compared the findings of two nationally representative surveys of public attitudes towards people diagnosed with schizophrenia, depression and alcohol use disorder in Germany. The first survey was completed in 1990 (n = 3067), with the second survey being conducted in 2011 (n = 2951). The research concluded that in 2011, the German population were more inclined to endorse biomedical explanations of schizophrenia, but there was a trend in the opposite direction regarding depression and alcohol dependence as being less attributable to biomedical causal factors. The research indicated that attitudes towards people with schizophrenia had worsened by 2011, whereas there were no conclusive shifts in attitudes towards people with the other two disorders.

A series of meta-analyses conducted by Kvaale et al. (2013) investigated the way in which biogenetic explanations of mental health difficulties affected stigma. Twenty-eight studies were included (details of the countries in which the studies were conducted were not provided). The meta-analyses indicated that biogenetic explanations for mental health difficulties were found to reduce blame and that there was no indication that these explanations typically affected the perceived need for social distance. However, the meta-analyses found that biogenetic explanations were associated with increased pessimism and increased support for stereotypes suggesting that individuals with psychological problems were dangerous (however, the authors caution that this finding may be a consequence of a publication bias) (Kvaale et al. 2013). The findings that Kvaale et al. (2013) obtained highlight the need to approach 'stigma' as a multifaceted concept that has different associations with biogenetic explanations for mental health difficulties.[1] Moving forward, it will also be important to unpack more precisely the general public's understanding of 'biogenetic explanations.' This is particularly pressing in light of the field of *epigenetics* and the rapidly evolving understanding of how genetic factors interact with environmental factors to shape behaviour.

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[1] These associations may be mediated by cultural factors. For example, Pirutinsky et al. (2010) found that the high value placed by US-based Orthodox Jews on marriage, parenthood and the well-being of children and descendants may have contributed to the finding that within their communities—in contrast to other populations in the USA—biogenetic accounts of mental health difficulties were linked with increased stigma, for both the sufferer and their relatives.

Developing a More Nuanced Understanding of the Associations Between Explanatory Models and Stigma

Research conducted by Liddell et al. (2005), which investigated outbreaks of a form of emotional distress called *ufufunyane* in South Africa in the early twentieth century, illustrates the way in which explanations can be multilayered. The outbreaks occurred in the context of Zulu men leaving their families to move far from their homes to get work. This research made a distinction between two levels of explanation of ufufunyane—proximate (i.e. *how* the condition is caused) and ultimate (i.e. *why* it is caused) causes. The ultimate cause of ufufunyane was believed to be the spirits of dead migrant Zulu workers possessing colleagues so that the spirit might return with them to assume an ancestral role. Examples of proximate causes however included 'sexual infidelities, violations of taboos, lack of ritual observances, and general breakdown in traditional family life that accompanied the prolonged absence of a head of household' (Liddell et al. 2004, p. 694). This example highlights how differentiating between levels of explanation may be advantageous for understanding how stigma related to mental health difficulties might develop. It is likely that the relationship between explanatory models for mental health difficulties and stigma will be influenced by the context in which people employ these explanations and the implications that these have for social acceptance within these contexts. A variety of factors [including the nature of the mental health difficulties; the level of contact that people have with those experiencing these difficulties, and particular life domains where this contact takes place (e.g. work, marriage, friendship, etc.)] will interact dynamically to shape the experience of stigma.

Prejudice and Mental Health Services

There is evidence suggesting that prejudices exist within the health sector that hinder the provision of care for those with mental health difficulties (Lawrence and Coghlan 2002). Indeed, it has been posited that mental health professionals themselves are one of the most effective and efficient transmitters of mental health-related stigma (Kleinman 2009). Patients have reported experiencing discriminatory or stigmatizing behaviours in psychiatric service settings as well as physical health care contexts (Hansson and Markstrom 2014). For example, research conducted in Zambia found that 76% of health care professionals who were sampled would have been concerned about being in close proximity with people who had received treatment for mental health difficulties (Kapungwe et al. 2011).

Individuals diagnosed with complex mental health problems (such as schizophrenia) can be subject to discriminatory attitudes by health care professionals regarding their decision-making capabilities. As a result, opinions and protestations expressed by the individual experiencing the mental health difficulties are often discredited or, even worse, labelled as one or more symptoms of their illness (Chamberlain 2006, p. xii). A review of qualitative studies investigating stigma experienced by individuals diagnosed with schizophrenia who were being treated in the community found that these individuals felt that the discriminatory and stigmatizing behaviours of health care professionals led them to believe that they were not taken seriously, denied the opportunity to establish a normal doctor–patient relationship, treated in a paternalistic way without respect and/or unable to access information relevant to their disorder and treatment options (Mestdagh and Hansen 2013). This is illustrated by the comment, by one of their interviewees who had experienced mental health difficulties, that 'if you complain and want to change doctors and you have a lot of opinions about your treatment, you can be called an "uncooperative patient"' (Tidefors and Olin 2011, p. 5).

Stigma and Help-seeking Behaviour

The experience of stigma affects the capacity and willingness of people with mental health difficulties to seek help, resulting in limited treatment efficacy or an increased risk of relapse in remitted individuals, which can in turn lead to an amplification of negative attitudes and discrimination (Sartorius 2007). Evans-Lacko et al. (2012a) explored the association between public views, self-stigma and help-seeking behaviour in individuals in 14 European countries (affiliated to the Global Alliance of Mental Illness Advocacy Networks [GAMIAN] study). The findings indicated that people with mental health difficulties living in countries with less-stigmatizing attitudes showed superior rates of help-seeking behaviours, increased utilization of treatment and more favourable perceptions about the accessibility of relevant information, in addition to comparatively low rates of self-stigma and perceived discrimination. Clement et al. (2015) conducted a recent systematic review investigating mental health-related stigma as a barrier to help-seeking. Of 144 studies included in the review, 99 had been carried out in the USA or Canada.

A further 20 had been conducted in Europe, 10 in Australia/New Zealand, 8 in Asia and only 1 study in South America. Overall, the findings indicated that stigma related to mental health difficulties is a significant impediment to people seeking help from services for these difficulties.

Although stigma is recognized as a universal phenomenon, it has been argued that it is a bigger barrier to accessing treatment in low-resource settings (Thornicroft et al. 2010). Ssebunnya et al. (2009), in research conducted in Uganda, found that self-stigma can delay help-seeking as well as elevated levels of rejection and shame. Reflecting on the situation in 'developing countries,' Mascayano et al. (2015) stated that mental health-related stigma constitutes 'a major problem related to help-seeking in people with mental health difficulties' (p. 1). However, there have been comparatively few studies conducted investigating mental health-related stigma in LMICs generally and fewer still that have investigated the impact this stigma has on help-seeking in LMICs in particular.

Diagnostic Overshadowing and Mental Health

It is not just with regard to accessing mental health services that stigma can be associated with difficulties. Prejudicial attitudes of health care professionals can also result in the person with mental health difficulties (particularly complex mental health problems) compared to a person without no mental health difficulties receiving less care for co-morbid physical health difficulties, thereby increasing the individual's risk of a poor outcome for co-morbid physical illness. For example, evidence from Uganda suggests that negative attitudes from healthcare professionals are manifested in a lack of adequate consultation and consent about treatment (Ndyanabangi et al. 2004). The experience of comparative delays, being humiliated or encountering elevated levels of suspicion about the legitimacy of physical complaints has also been reported by individuals with psychosis in Sweden (Tidefors and Olin 2011). The phenomenon of 'diagnostic overshadowing,' where signs/symptoms of physical health difficulties are misattributed to co-morbid mental disorders, can lead to the under-detection and/or inappropriate treatment of the physical health difficulties (Thornicroft et al. 2007). For example, evidence indicates that people experiencing mental health difficulties have reduced access to primary health care services (Levinson et al. 2003). Care for cardiometabolic risk is reported to be inferior (Desai et al. 2002), even though the incidence of physical health difficulties among people with complex mental health difficulties is elevated compared to the general population (Phelan et al. 2001; Jones et al. 2004). A co-occurrence of comparatively high levels of physical illness and reduced access to appropriate treatment has contributed to an elevated probability of premature death among individuals with a mental illness (Harris and Barraclough 1998).

Adherence to Treatment

In a patient survey by nurses conducted during the *Schizophrenia Guidelines Project* in the USA, stigma was identified as one of the two biggest reasons for medication non-adherence—the other reason being the side effects of medication (Hudson et al. 2004). With pharmacotherapy being the mainstay of treatment for schizophrenia, non-adherence can have a pronounced impact on people's capacity to achieve treatment goals. Stigma can also impact negatively on individuals' capacity to adhere to psychosocial interventions. In a study in Hong Kong, Fung et al. (2008) conducted a study exploring how adherence to psychosocial treatment was related to self-stigma in 86 participants. In this study, higher levels of self-stigma predicted poor psychosocial treatment attendance. Indeed, self-stigma and self-esteem were the factors most strongly related to adherence to psychosocial treatment.

The Impact of Stigma on Families of Individuals with Mental Health Difficulties

The experience of stigma is not confined to the individual with mental health difficulties alone but casts its shadow over their families across generations. This has been referred to as 'courtesy stigma' (Goffman 1963) or 'associated stigma' (Quinn and Knifton 2014). Research conducted by Shibre et al. (2001) in Ethiopia investigated the stigma experienced by family members of individuals experiencing mental health difficulties. A total of 75% of family members (of individuals with either psychotic or mood disorders) indicated that they had experienced stigma, and 37% stated that they wanted to withhold their relative's mental illness from others (Shibre et al. 2001). Research conducted in Uganda by Kigozi et al. (2008) found that many families make concerted efforts to hide the mental health difficulties that their relative is experiencing. Research from China determined that more than half of the relatives of people with schizophrenia who were surveyed indicated that they concealed the occurrence of schizophrenia within their family (Phillips et al. 2002). Similarly, Thara et al. (2003) highlighted that the families of individuals with schizophrenia in India hid the condition because they were fearful about the implications that this would have for the likelihood of the individual getting married and/or accepted by their local community.

The Impact of Stigma on Marital Status

The research evidence has demonstrated that the experience of stigma can have important ramifications for people's prospects of marriage. A study of across five different European countries that recruited 404 people diagnosed with schizophrenia aged 18–65 years found that two-thirds of participants were 'single,' with only 17% of the sample reporting that they were married (Thornicroft et al. 2004). Byaruhanga et al. (2008) in a study conducted in Uganda found that individuals experiencing mental health difficulties and their families may experience more difficulty in getting married. In Chinese societies, individuals experiencing mental health difficulties (and potentially their siblings too) are traditionally prevented from marrying (Ng 1997). Married people who develop schizophrenia in China also experience divorce rates nearly ten times the population norm (Phillips et al. 2002). A study conducted in Hong Kong by Lee et al. (2005) compared the levels of stigma experienced by people with schizophrenia (n = 320) with those experienced by individuals with diabetes (n = 160) and found the following: (1) around one-third of participants indicated that their partner had ended their relationship or initiated divorce proceedings as a consequence of their mental health difficulty; (2) 60% of participants in a relationship anticipated that their partner would end their relationship if they disclosed that they had mental health difficulties. In India, the Vellore study on public attitudes (Verghese and Beig 1974) found that approximately two-thirds (65%) of respondents objected to the idea of a marital alliance with the household of a mental patient. Koschorke et al. (2014) noted that disclosing a diagnosis of schizophrenia was of particular concern for unmarried patients with schizophrenia in India, and it was usually concealed from potential spouses and their family. A study in Southern India found that although 70% of young adults with a diagnosis of schizophrenia went on to marry in the following ten years, concealment of the diagnosis was a key factor in this process (Thara and Srinivasan 1997). Evidencing the extent of self-stigma associated with this issue, Malhotra et al. (1981) found that three-quarters of the participants with mental disorders that they recruited in India were opposed to the idea of marital alliance for themselves.

Stigma in the Work Environment

Drawing on data from interviews conducted with 732 participants with schizophrenia recruited through centres in 27 different countries associated with the INDIGO (International Study of Discrimination and Stigma Outcomes) Research Network, Thornicroft et al. (2009) determined that the rates of anticipated as well as experienced discrimination were uniformly high across all of the participating countries. The authors concluded that existing strategies such as laws relating to disability discrimination were not sufficient to address the problem. It was suggested that interventions were required that aimed to specifically improve the self-esteem of people with mental illness.

Grove (1999) highlighted the cruel irony of people experiencing mental health difficulties having a lower rate of employment relative to other disabled groups while simultaneously being more likely than other groups to want to be in employment. It has been suggested that discrimination in the workplace contributes to this low employment rate among people with severe mental illness (Stuart 2006; Latimer 2008). Employment discrimination has been identified by people experiencing mental health difficulties as one of their most frequent stigma experiences (Gaebel et al. 2005). Indeed, one-third of people with mental health difficulties in the USA report having been rejected for a job after their mental health difficulties became known, and in some instances, the offer of employment was withdrawn once the individuals' mental health difficulties had been noted (Wahl 1999). Compared to individuals with physical disabilities, twice as many people with mental health difficulties (i.e. the majority of individuals) expect to experience employment-related stigma (Roeloffs et al. 2003). In a study that recruited 320 outpatients diagnosed with schizophrenia in Hong Kong (Lee et al. 2005), 55% of respondents reported deliberately concealing their illness from co-workers, and 70% indicated that opportunities for promotion would be negatively impacted by being open about their mental health difficulties. Research conducted in India by Loganathan and Murthy (2011) highlighted that males reported concealing their mental health difficulties from others when applying for jobs. Research suggests that over time, unemployed people with mental health difficulties may consider themselves to be unemployable and may desist from seeking employment (Wahl 1999).

Mental Health Implications of Stigma

It has been claimed that the aversive impact of prejudice and stigma of individuals experiencing mental health difficulties can potentially exceed the disabling impact of mental health difficulties (Hinshaw and Stier 2008). Krajewski et al. (2013) have referred to stigma as a 'second disease' in that it can be both the cause and also the effect of mental health difficulties. The emergence of stigma thus starts a vicious cycle which leads to that individual experiencing decreasing self-esteem and self-confidence. Wright et al.'s (2000) research with outpatients diagnosed with schizophrenia demonstrated that directly experienced stigma can affect perceptions of mastery that can have a knock-on influence on positive and negative self-esteem. Alarmingly, Schomerus et al. (2015) in a study that drew data from 25 European countries found that the social acceptance of people with pronounced mental health difficulties was inversely related to age-standardized national suicide rates occurring in the same year.

The Importance of Acceptance and Civility

Research by Rose et al. (2011) found that the experience of stigma and/or discrimination was widespread among 75 individuals diagnosed with schizophrenia who had been recruited from 15 different countries. However, the research also identified reports by participants highlighting occasions when a diagnosis of schizophrenia appeared to confer perceived benefits for the participants (referred to as incidences of *positive discrimination* by the authors). However, Rose et al. (2011) noted that these apparent experiences of 'positive discrimination' tended to actually involve the person being treated the way a person should normally expect to be treated in a civil society. In other words, participants tended to perceive evidence of civility from others as an advantage of their diagnosis rather than a fundamental right. Rose et al. (2011) observed that the absence of anticipated discrimination leaves individuals with mental health difficulties 'feeling grateful.' This highlights the potential benefits that may come from supporting members of the public to act with civility and acceptance towards those experiencing mental health difficulties. Particular stakeholders such as community leaders may have an important role to contribute to this process. It is important to appreciate that particular cultural practices and events will provide symbolic gravitas for demonstrating the acceptance of people with mental health problems. An anecdotal example of this is provided from a *Sibling Series* e-mail communication of Families Alliance on Mental Illness (FACEMI) (Nirmala 2015) in which a father described the inclusion of his son who had been diagnosed with schizophrenia in the wedding festivities of the younger sibling. Wedding celebrations in the Indian context involve a lot of rituals in a community context. According to the man's father, this social inclusion was possible because of

> '[a]ffection of friends and relatives, cooperation of bride's parents, planning proper medication, allocating responsibilities, … ignoring his mistakes and appreciating even the little work…' (Ibid.)

A review of qualitative research studies investigating stigma experienced by individuals diagnosed with schizophrenia (Mestdagh and Hansen 2013) concluded that community mental health care professionals have a key role to play in raising awareness about mental health-related stigma in health services and the broader community so as to optimize the acceptance of clients in society. Specifically, the authors suggested that community mental health care professionals should act to empower individuals with mental health difficulties to strengthen their ability to function well in the community (Mestdagh and Hansen 2013).

Efforts Aimed at Reducing Stigma

There are a number of strategies that have been proposed for reducing the stigma experienced by individuals with mental health difficulties. Clement et al. (2010) consulted with a panel of 32 experts attending an international conference on mental health stigma. Consensus was reached that the use of 'recovery-oriented' (i.e. supporting the notion that people with mental health difficulties can still lead full and meaningful lives) and 'see the person' messages (advocating a holistic appreciation of the person rather than the illness) were to be recommended and that 'social inclusion/human rights' messages and efforts aimed at highlighting the high prevalence of mental health difficulties are also worthy of consideration (Clement et al. 2010).

There has been consistent support for the importance of *Social Contact Theory* (see Pettigrew and Tropp 2006) in reducing mental health-related stigma. 'Social Contact' initiatives aim to break down stigma by facilitating opportunities for people with no experience of mental health difficulties the chance to meet with those who have had mental health difficulties. Extending earlier work on *Intergroup Contact Hypothesis* (Allport 1954), Pettigrew (1998) proposed that for maximum benefit the nature of the social contact should be such so as to facilitate:

1. Equal status between the groups in the situation
2. Common goals
3. Intergroup cooperation
4. Support of authorities, law, or custom
5. Friendship potential.

Evans-Lacko et al. (2012b) investigated the impact of social contact on stigma by administering questionnaires to 403 participants (70% paper, 30% online) living in England. A total of 83 of these individuals completed online questionnaires at four to six weeks' follow-up. The results were positive and emphasized the importance of providing opportunities for positive social contact. The findings also supported the idea that social contact interventions can be implemented and effective at a mass level. In another study conducted in England, Clement et al. (2012) investigated whether recorded video clips compared to live social contact interventions were superior to reducing stigma by utilizing a randomized control trial methodology with 216 student nurses. Nurses were randomly allocated to one of three conditions: (1) viewing a DVD of mental health service users and informal carers discussing their experiences (DVD); (2) watching a service user and carer talk about their experiences in person (live); or (3) attending a lecture that focused on stigma and mental health (Control). There were no significant differences between the DVD and Live conditions. The combined social contact groups (DVD/live) demonstrated superior outcomes compared to the Control condition, which were maintained at four-month follow-up. The DVD was adjudged to be the most cost-effective option, and the live sessions were considered the most popular.

Corrigan et al. (2012) conducted a meta-analysis of outcome studies evaluating efforts to reduce stigma. The participants recruited to the 79 independent studies came from 14 countries across Europe (N = 22,179), North America (N = 14,307), South America (N = 63), Asia (N = 1299) and Australia (N = 516). Notably, however, there were no participants from Africa recruited to any of the studies. Both education and social contact were found to have positive effects on lowering mental health-related stigma experienced by both adolescents and adults. Social contact was however found to be superior than education for lowering stigma experienced by adults. The inverse was the case for adolescents, with education being found to be more effective. The authors concluded that face-to-face contact was superior to contact by video. More recently, Griffiths et al. (2014) conducted a meta-analysis of randomized controlled trials investigating interventions for reducing stigma related to mental health difficulties. The vast majority of these studies were conducted in HICs. Only one study had been conducted in a middle-income country [i.e. Turkey, see Bayar et al. (2009)], and no studies had been conducted in low-income countries, as identified in the review. The results of the meta-analysis indicated that there was no evidence supporting the idea that stigma interventions were efficacious in reducing self-stigma or perceived stigma.

A systematic review conducted by Mehta et al. (2015) sought to address concerns that research studies investigating anti-stigma campaigns had focused too much on short-term outcomes and that the research has tended to have been conducted in HICs. Of the 80 studies included in the review, 11 had been conducted in middle-income countries and none had been carried out in low-income countries. The 21 studies with medium to long-term follow-up outcomes (i.e. a minimum of four weeks' follow-up) for which effect sizes could be calculated failed to support the notion that social contact interventions were superior to other forms of intervention at improving attitudes towards people with mental health difficulties. The reasons why the post-intervention superiority of social contact interventions is not retained in the longer-term remain unclear. Mehta et al. (2015) and Thornicroft et al. (2015) have highlighted the need for more rigorous research to be conducted into anti-stigma campaigns—particularly in LMICs.

Mittal et al. (2012) conducted a review of empirical studies that have specifically investigated self-stigma reduction strategies. Of the 14 studies included in the review, only one was conducted in a middle-income country (i.e. China; Fung et al. 2011) and none was conducted in low-income countries. In particular, two prominent approaches for self-stigma reduction were identified: (1) interventions aimed at altering the stigmatizing beliefs/attitudes held by the person and (2) interventions aimed at enhancing skills for tolerating self-stigma through improved help-seeking behaviour, self-esteem and/or empowerment. The review indicated that the second approach in particular appears to be increasingly recognized by stigma experts as offering promise (Mittal et al. 2012). It is suggested that high-risk groups be targeted to pre-empt the potential development of self-stigma so that the impact on the individual can be reduced (ibid.).

Rüsch et al. (2005) have highlighted how people who have experienced mental health difficulties ('consumer' groups in particular) can be a powerful resource in reducing stigma. In addition, research has demonstrated that involving people with a lived experience of mental health difficulties in the care and treatment of others can serve to reduce stigma. Specifically, research conducted in Ontario, Canada, found that *Peer Support Workers* do not regard stigma as a barrier for getting work and they were more likely to be employed (Ochocka et al. 2006). In addition, Mowbray et al. (1998) reported that Peer Support Workers acknowledged that through their work they were altering attitudes to mental health difficulties and in turn were serving to reduce stigma.

Anti-Stigma Programmes

Time to Change is an anti-stigma campaign run by leading mental health charities in the UK (http://www.time-to-change.org.uk/). This campaign conducts an annual survey of the English population to investigate the attitudes and behaviours that are directed towards people experiencing mental health difficulties. The biggest improvement in public attitudes to date took place during 2013, with a 2.8% improvement being observed between responses to the 2012 and 2013 surveys. Since *Time to Change* began in 2007, the overall improvement has been 6.4%. Since the launch of the second phase in 2011, there has been a 4.8% improvement. Although a range of similar anti-stigma campaigns to *Time to Change* have been rolled out in other HICs [e.g. in Denmark (One of Us), New Zealand (Like Minds Like Mine) and Canada (Opening Minds)], there is a marked scarcity of national campaigns in LMICs (Sartorius and Schulze 2005; Mascayano et al. 2015).

Reducing Stigma in Low- and Middle-income Countries

Quinn and Knifton (2014) pointed out that 'most approaches towards stigma have been developed in the context of high-income countries using Western constructs of mental health' (p. 555). Reflecting on their research in Uganda, Quinn and Knifton (2014) warn that the scaling up of global anti-stigma that lack cross-cultural validity could potentially cause harm in LMICs because of a lack of cultural fit. These concerns in combination with the equivocal findings in relation to national campaigns in HICs (Link 2013) and the high costs of these campaigns (Mascayano et al. 2015) highlight the need to engage in careful consideration about how best to address mental health-related stigma in LMICs. Mascayano et al. (2015) pointed out that an overall lack of political will to prioritize mental health in LMICs will also detract significantly from efforts to tackle mental health-related stigma in these contexts.

Reflecting on the paucity of published research relating to the efficacy of stigma reduction initiatives in LMICs, Semrau et al. (2015) noted that in particular there was an absence of studies with long-term follow-up. It was concluded that there was insufficient evidence to determine which types of intervention may be both feasible and efficacious in LMICs (Semrau et al. 2015). No firm conclusions were made by the authors about the extent to which intervention programmes developed in HICs needed to be tailored to local contexts to be acceptable for implementation at scale in LMICs (ibid.). Emphasizing the need for pragmatism in the face of inadequate resources and no clear consensus on evidence-based approaches, Mascayano et al. (2015) proposed that to be most effective, anti-stigma interventions in LMICs should draw on existing strengths to reduce stigma and discrimination. Further details of the specific examples of community resource and strength are available from Mascayano et al. (2015) but these include (1) the willingness of communities to accept and protect people in Jamaica; (2) the social solidarity that can be fostered through being offered work opportunities in local businesses in Latin America; (3) opportunities to participate in traditional/religious healing rituals, for example, musical rituals that are characteristic of Sudanese culture; (4) creating flexible job opportunities for agrarian workers in rural China; (5) utilizing family and extended kinship networks, such as the communal support in Ethiopia and Tanzania, to provide support for people with mental health difficulties; and (6) assigning cultural/spiritual importance to psychotic experiences (which could be interpreted as prophetic experiences) in countries such as Uganda.

Mascayano et al. (2015) concluded that efforts to decrease mental health-related stigma in LMICs and beyond will prove most successful if an emphasis is placed on promoting the possibility that individuals with mental health difficulties can fulfil role expectations. This can be contrasted with narrower attempts to undermine or challenge generic stereotypes such as people with mental health problems are incompetent. An example of this kind of approach that Mascayano et al. (2015) highlighted is the *What Matters Most* programme that was developed for Chinese migrant groups in New York who were experiencing stigma associated with their mental health difficulties (see: Yang et al. 2006, 2014). This approach places specific focus on embracing cultural factors and strengths that exist within particular contexts for tackling the impact of stigma. This could be a helpful template moving forward for addressing stigma in other resource-scarce settings such as LMICs.

Recently, a broad distinction has been made between two approaches that can be adopted in efforts aimed at reducing mental health-related stigma:

(1) 'Appeals to normalcy' (based on the assumption that people with mental health difficulties are just like everyone else) and (2) 'Solidarity' (calls for the general public to stand together with individuals diagnosed with mental health difficulties) (Corrigan 2016). It is suggested that efforts aimed at promoting normalcy might inadvertently encourage people to conceal aspects of their experience to conform with a hypothetical norm. Corrigan (2016) raises the possibility that celebrating diversity and fostering solidarity around a positive identity of mental health difficulties may be conducive to reducing stigma. Moving forward, Corrigan (2016) suggests that efforts aimed at reducing mental health-related stigma should consider the comparative merits and demerits that the 'normalcy' versus 'solidarity' approaches have for particular contexts.

Conclusions

The material presented in this chapter has served to highlight the multifaceted nature of stigma and the way in which it can manifest in a variety of beliefs, attitudes and/or behaviours. Stigma can be imposed upon oneself, actually experienced at the hands of others, or inferred to be present in the thoughts, intentions and behaviours of others. The extent to which particular explanatory models for mental health difficulties may be stigmatizing seems to vary across time and cultural settings, which suggests the prominent role that context plays in shaping these relationships. The plurality of ways in which stigma can manifest makes it highly unlikely that a uniform strategy for resolving it will be found. Instead, there is a need to address stigma in the particular contexts in which it is felt and experienced. In addition to operating to shift public attitudes about those who have experienced mental health difficulties, there will be a need to operate at an individual level to foster people's capacity to cope with self-attacking thoughts that they might have experienced.

Health and mental health professionals are not immune from propagating stigma. This may manifest in both implicit and explicit forms—taking a more passive form in that the needs of people with mental health problems are not assertively pursued, or an active form when prejudicial attitudes are expressed. This can serve to undermine individuals' experience of physical and mental health services. Stigma related to mental health difficulties can also have a profound impact on people's interpersonal relationships and their employment prospects. It is clear that the experience of stigma can impact negatively on individuals' mental health in two main ways: (1) stigma can reduce the likelihood of individuals seeking health for mental health difficulties; (2) it can compound the levels of distress the person is experiencing because they further internalize notions of being defective.

National campaigns have been launched in a range of HICs to reduce stigma. Particular aspects of these initiatives including social contact schemes and emphasizing recovery appear to offer promise. The findings regarding large-scale stigma reduction programmes remain largely equivocal though. To date, the bulk of research has been conducted in HICs, and more research into these issues in LMICs is required. There are promising examples of how existing community strengths in LMICs can be harnessed to help reduce stigma. The pragmatism that these schemes have demonstrated could provide important learning opportunities for how HICs can progress plans even more effectively. It seems that focusing on what individuals are able to do rather than serving to dismiss public attitudes about what they supposedly cannot do might be a fruitful road forward.

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14

The Effects of Societal Violence in War and Post-War Contexts

Hanna Kienzler and Peter Locke

Since the Second World War, changes in strategic targets, weapon technologies, and combat techniques have led to a significant increase in the number of civilian casualties of war, reaching 90% of total casualties in some cases (Turpin 1998). Social support networks, local economies, and food production systems also erode in such contexts, disproportionately affecting the lives of the most vulnerable people in society, including older people, people with disabilities, lactating women, and children (Pedersen 2002). Additionally, armed conflicts have consistently resulted in large flows of refugees and internally displaced persons. The latest UNHCR Global Trends Report shows that there were 51.2 million forcibly displaced people worldwide at the end of 2013, the highest number since 1989.

Armed conflict and related violence can have devastating and lasting consequences for mental as well as physical health. In 2011, the journal *Nature* published the widely discussed article "Grand Challenges in Global Mental Health," in which the authors—respected scientists and leaders in health policy—consider the mental health situation in states recently emerging from armed conflict or under endemic and protracted violence to be particularly

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grave. They state: “Extreme poverty, war and natural disasters affect large swathes of the world, and we still do not fully understand the mechanisms by which mental disorders might be averted or precipitated in those settings” (Collins et al. 2011, p. 30). In order to fill this gap in knowledge, they advocate immediate research and prioritizing of policies for adequate and sustainable interventions. Their call for action is backed by epidemiological surveys that have made strikingly apparent that armed conflicts exacerbate overall rates of mental disorders (Tol et al. 2011). In order to reduce the global burden of mental health conditions, a number of organizations have set out to foster processes of healing and to generate improved mental health policies and services. Much of their work is guided by standardized “evidence-based treatment packages” developed by researchers and clinicians to improve approaches to mental health treatments in war-torn societies.

Such interventions targeting psychological trauma and other ostensibly war-related mental health conditions have not gone unquestioned. In recent years, researchers have produced an extensive body of literature criticizing the inappropriate transfer of Western psychological assumptions to contexts where they may not be meaningful (Bemme and D’souza 2014; Kienzler and Pedersen 2012). Critics argue that such Western conceptions are based on understandings of normality and deviance that focus solely on problems located within the individual and lack a developed conceptual vocabulary for the relational, social, communal, and cultural dimensions and determinants of psychological suffering (Kienzler 2008). Instead, they show that remembering and forgetting traumatic experiences depend on socially and historically contingent memory systems that inscribe trauma not only in the body and the brain but also in the social and political processes that aim to regulate public and private recollection (De Jong, K. et al. 2003; McNally 2003). It is argued that disregarding the importance of sociocultural, political, and economic contexts contributes to reductive understandings of the psychosocial complexities of trauma that rely on potentially ethnocentric diagnostic framings like posttraumatic stress disorder (PTSD) and depression. As a result, advocates of humanitarian psychiatry may fail to acknowledge the role of local patterns and idioms of distress, long-term health effects, psychosocial consequences, help-seeking behavior, and culturally specific approaches to healing (Pedersen 2002).

In this chapter, we will explore the effects of societal violence on people’s lives and mental health in war and post-war contexts by introducing key perspectives and debates and highlighting the complex interrelations of trauma-focused pathways, psychosocial pathways, and local expressions of distress. In the process, we do not seek to disregard one or another perspective, but rather aim to illuminate the key insights emerging from the critical debates in the field and argue for a richer cross-cultural and interdisciplinary understanding of emotional distress in war and post-war situations.

Societal Violence in War and Post-War Contexts

Violence is a social phenomenon and, as such, affects our notions of life and death, good and evil, and sickness and health in manifold and complex ways (Jenkins 1998). Expressions and experiences of violence are increasingly determined and verified by research focusing on physical and psychological trauma, PTSD, and related disorders such as depression and anxiety. While certainly important, these medicalizing approaches often fail to pay attention to the details of the meaning and specific material forms of violence in particular historical and social contexts (Desjarlais et al. 1995). We argue that it is crucial to problematize also the communicative effects, symbolic use, performative quality, and lived experience of violence in order to gain a better understanding of how it is linked to personal and social well-being, and to provide answers to questions concerning the psychological, cultural, and moral consequences of violent acts (Desjarlais and Kleinman 1997).

Violence as means for communication is capable of transmitting messages that devalue or destroy previously held referents, social conventions, and identities (Feldman 1995). For example, Nordstrom's (2004) study about violence in Sierra Leone powerfully highlights the complex symbolic and sociopolitical messages that troops conveyed by cutting off voters' hands and arms in attempting to impose a boycott of the election. The message was obvious: "the voters are 'dis-armed'" (p. 63). In a different context, Taylor (2002) describes how in Rwanda perpetrators frequently inscribed "difference" into the bodies of their adversaries by transforming them into the figures that they were supposed to represent. The violent acts, ranging from stuffing people into latrines to cutting their Achilles tendons at militia roadblocks, were patterned on particular local conceptions of bodily flow and blockage and turned victims into recognizable "Others."

Expressions of violence are always local products, created out of local, regional, and global flows of knowledge and representation. Thus, although violence may be a very personal and subjective experience, "larger social actors such as the state, international organizations, and the global media, as well as transnational flows in finances and people" are all involved in the creation, maintenance, and suppression of violence (Das and Kleinman 2000, p. 2). Linking lived experience with global political economy and inequality has led social scientists to coin the concept of "structural violence." It makes apparent that in war and post-war contexts militarized violence is connected to other forms of violence—some of them long-standing aspects of global and local political orders, others shaped by more recent global power shifts—including domestic violence as well as structural barriers that take the form of institutional, social, and economic stressors and effectively prevent individuals from achieving tolerable conditions for day-to-day life and survival, let alone their full potential (Panter-Brick et al. 2011; Farmer 2004). Galtung (1985) explains:

> Structural violence was then seen as unintended harm done to human beings (…), as a process, working slowly as the way misery in general, and hunger in particular, erode and finally kill human beings. If it works quickly it is more likely to be noticed and strong positions for and against will build up so that moral stands emerge (p. 146).

As war-related violence tends to be starkly visible, it has the potential to shock people into action and to trigger a flurry of short-term emergency interventions. The everydayness of poverty and exclusion, on the other hand, receive less attention—partly due to the fact that international donor money is lacking to finance longer-term, culturally appropriate, and sustainable interventions. Response to violence is thus not at all a straightforward or morally clear process (Redfield 2013).

To grasp the impact of both political and structural violence on individual lives and entire communities, it is important to move beyond "emergency" that is, death, disease, and trauma, to include the pervasive effects of the destruction of the social fabric of society (Das 2007). Examples of these deep impacts of societal violence in war and post-war settings are receiving growing attention in the academic literature. For instance, Panter-Brick et al. (2011) carefully describe the connections between domestic violence and structural and community violence among Afghan families. They found that interpersonal violence destroyed "family harmony" and solidarity to the point of attempted suicides: "Some adolescents reported having been rushed to hospital after ingesting rat poison, and female caregivers having wanted to throw themselves off the roof 'because of all the beatings'" (p. 360). Respondents in the study clearly highlighted the links connecting interpersonal violence with chronic socioeconomic stressors and acute episodes of political upheaval, insecurity, and violence.

In a different context, Olujic (1998) discusses the parallels between the patterns of everyday dominance and aggression during times of peace and war in Croatia and Bosnia-Herzegovina. According to her, aggression or violence against women was a means by which combatants applied traditional honor/shame ideology to show who controlled "sexual property" and the political process. By turning women into sociopolitical objects, they effectively denied them their individuality and, related to this, their rights. Das (1996), on the other hand, discusses links between increasing abduction and rape of women and the burgeoning nationalist imaginary of anti-colonial movements in India by tackling the question of "[how it is] that the imagining of the project of nationalism in India came to include the appropriation of bodies of women as objects on which the desire for nationalism could be brutally inscribed and a memory for the future made" (p. 68).

These examples make apparent that within the full range of militarized, political, and structural violence, power relations between perpetrators and victims are negotiated and driven by ideas and imaginaries of identity, fantasy, desire, and reputation (James 2010).

In the following sections, we will focus on the devastating and long-lasting mental health and psychosocial consequences that such forms of societal violence produce, and discuss different disciplinary and interdisciplinary approaches that attempt to understand and improve the well-being of individuals and entire populations emerging from war and violence.

The Effects of Societal Violence on Mental Health

It is widely recognized that violence is a cause of suffering, general ill-health, and mental health problems. Much of the research in recent years sought to establish that the experience of violence in war and post-war contexts leads to traumatic memories, which may result in PTSD, depression, anxiety, and other mental health problems. PTSD in particular has become a "signature injury" functioning as a potent "idiom of distress" (Hautzinger and Scandlyn 2014). Fassin and Rechtman (2009) state, "[T]rauma has become a major signifier of our age," in that we talk about traumatic events such as rape, genocide, torture, slavery, terrorist attacks, and natural disasters in the same way: "one signifier for a plurality of ills signified" (p. xi). However, this is not to say that there is agreement on how violence gets under the skin and how it should be dealt with. In the psychiatric arena, there are growing tensions between different approaches seeking to link exposure to violence to mental health outcomes.

Mental Health and Psychosocial Approaches

There is a perceived split between advocates of trauma-focused and psychosocial understandings related to the assessment of mental health needs in conflict and post-conflict settings (Miller and Rasmussen 2010). Trauma-focused approaches attempt to establish a direct connection between exposures to violence (e.g., physical assault, demolition of one's home, disappearance and killing of loved ones, killing of livestock) and mental health. Research has revealed that cumulative trauma has the capacity to cause higher psychiatric symptom levels assuming that "each individual who has experienced or is experiencing traumatic events will develop PTSD after reaching a certain threshold of traumatic exposure" (Neuner et al. 2004, p. 2).

To assess the needs of survivors of trauma, culturally and linguistically validated screening tools have been developed based on symptom lists derived from different editions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and International Classifications of Diseases (ICD). The intention is to aid clinicians and policymakers to distinguish between different syndromes like acute stress disorder and identity disorder, and chronic PTSD (Hinton and Lewis-Fernández 2010; Pedersen and Kienzler forthcoming). Studies have largely focused on symptoms of PTSD, which, according to the DSM-5 (APA 2013), include four symptom clusters in addition to the history of exposure to traumatic events (criterion A): intrusion symptoms (criterion B), avoidance (criterion C), negative alterations in cognitions and mood (criterion D), and alterations in arousal and reactivity (criterion E). Further criteria include the duration of symptoms (criterion F), functional significance (criterion G), and exclusion of substance use or co-occurring medical conditions as causes (criterion H) (APA 2013).

Research that focuses on individual vulnerability following the exposure to trauma includes studies on war-affected people from all over the world. A recently conducted systematic review indicates an average prevalence of 15.4% (30 studies) for PTSD and 17.3% (26 studies) for depression in conflict-affected populations (Tol et al. 2011). Similarly, Joop de Jong's (2003) findings indicate that the prevalence of PTSD ranges from 15.8% to 37.4% in Algeria, Cambodia, Ethiopia, and Palestine. These rates are considerably higher than the average of 7.6% for any anxiety disorder and 5.3% for any mood disorder, which have been reported in 17 general populations participating in the World Mental Health Survey (Demyttenaere et al. 2004). However, researchers have cautioned that data related to trauma and associated health problems are often conflicting and challenging to interpret as various methods and instruments are employed for their collection, analysis, and reporting (Hollifield et al. 2002).

Overall, studies conducted among war-affected populations recognize that while trauma-related mental illness seems to decline steadily over time, a small subgroup of people with a high degree of exposure to trauma shows long-term psychiatric morbidity. In fact, a wide range of studies of populations including survivors of war, survivors of terrorist attacks, hospitalized survivors of motor vehicle accidents, and Gulf War veterans has highlighted that most survivors do not develop mental disorders (Paton and Violanti 2006; Lyons 1991). Research that emphasizes coping and resilience in survivors of war includes, for instance, investigations that document the psychosocial adjustment of young Cambodian refugees in Canada. Rousseau et al. (2003) argue that the trauma a family suffered before leaving their homeland and prior to the teenagers' birth seems to play a protective role at various times in adolescence with regard to externalized symptoms, risk behavior, school failure in boys, and social adjustment in girls. It is concluded that these reactions may be understood as overcompensation by the children of the survivors of a massacre, to whom the implicit duty to succeed has been passed on. Similar findings are reported by Ungar (2011) in a systematic review focusing on resilience among families exposed to human-made and natural disasters; Beiser et al. (1989) and Tousignant et al. (1999), who studied Vietnamese and Laotian refugees in Canada, respectively; as well as Eggerman and Panter-Brick (2010) among Afghan families and Barber (2008) among Palestinian youth.

Based on these and similar findings, guidelines and treatment protocols have been developed that focus on providing first aid in the aftermath of a disaster and more specialized interventions geared toward those with a high degree of exposure to trauma and with long-term psychiatric morbidity. Treatments for trauma-related health problems are various and include different forms of psychosocial, pharmacological, and cognitive-behavioral interventions (Kienzler and Pedersen 2012). As a consequence, a wide range of therapies is offered to individuals and communities suffering from psychological trauma, which has been shown to lead to competition between interventionists and sometimes confusion among service users (WHO 2003).

While the trauma-focused approach seems seductive in its simplicity, a growing number of researchers and interventionists consider it to be too one-dimensional and, thus, removed from what is actually happening in people's lives (Atlani and Rousseau 2000). It is argued that it is important to pay particular attention to the role of contextual factors in "shaping the mental health and psychosocial consequences of violence (…) rather than assuming a direct connection between traumatic events in creating symptomatology" (Tol et al. 2010, p. 35). Scholars also point out that evidence suggests that "organized violence (…) generates or exacerbates a host of highly stressful conditions or daily stressors, such as poverty, social marginalization, isolation, inadequate housing, and changes in family structure and functioning" (Miller and Rasmussen 2010, p. 8). Mental health is powerfully affected by social position and by the scale of social and economic differences within the population (Wilkinson 1996). In other words, both in contexts of war and peace, health and illness follow a social gradient: the lower the social and economic position, the worse the health status of a population (Commission on Social Determinants of Health 2008).

A number of psychiatrists and anthropologists argue that the quality of social life is one of the most powerful determinants of mental health and suggest a more integrated approach to mental health to examine the different pathways through which political and structural violence affect psychological well-being. For example, in the context of the Lebanese civil war, Farhood and his team (1993) showed that distress led to multifaceted health effects. While the war flared up periodically, daily hassles resulting from the breakdown in community services prevailed more uniformly and continuously. As a consequence, families reported that their mental health and physical health were strongly impacted by the economic consequences of a process of rapid inflation, not being able to ensure the basic needs of decent living, and the reduced possibility of encounter with relatives and friends. In Sri Lanka, on the other hand, people recalled distress connected to the "immediacy" with which violence hit, including sudden disruptions of life routines and the unexpected dissolution and disappearance of families after a seemingly ordinary workday. Feeling incapable of providing and protecting family members was experienced as devastating (Henry 2006). Again in a different context, Locke (2012) highlights that the emotional pain suffered by war veterans in Bosnia and Herzegovina could not be interpreted through the PTSD model alone, as it would lead to the illusion that their distress stemmed exclusively from war experiences. Rather, their suffering was powerfully linked to *post*-war hardships including "the way in which (…) they had come to feel abandoned, neglected and misunderstood by their communities and public institutions" (p. 5).

In order to capture these interlinked stressors and related health problems, interventionists following a psychosocial approach propose to transform short-term mental health interventions into extended mental health and psychosocial support programs and, related to this, institutional development (Abramowitz 2010). In this approach, emphasis is placed on the enhancement of government-driven policies, human resources and training, programming and services, research and program monitoring, and finances (Ventevogel et al. 2013). According to a recent review, advocated mental health and psychosocial support practices include counseling, providing and facilitating community-based social supports, structured social activities, provision of information, psychoeducation, and raising awareness (Tol et al. 2011). In some contexts of conflict, myriad forms of psychosocial support are delivered to people that are not always compatible. For example, Summerfield (1999) highlighted that a European Community Task Force (ECTF) review found that 185 of such psychosocial projects were carried out by 117 different organizations in the former Yugoslavia in 1995 (see also Locke 2012). Much of this work seems to have had limited long-term impact on the availability and quality of mental health care, due primarily to inadequate attention to and investment in local primary care and welfare infrastructures.

Despite debates surrounding the multiple treatment practices offered in the wake of conflicts, interventionists have largely come to an agreement to focus on population-based mental health approaches rather than individualistic ones (Patel et al. 2011). Population-based mental health interventions are described as “affordable, effective, acceptable, and culturally valid interventions at the community level” (Banatvala and Zwi 2000, p. 103). While allowing for more attention to sociocultural complexity than a trauma-focused approach, it is important to caution that in these particular biosocial environments, not only material resources but also rights, services (e.g., educational support, legal advice, health care) and opportunities to participate in the wider community are unevenly spread. In other words, people are not simply passive recipients of violence and culture but negotiate their life worlds actively depending on their particular social class, economic situation, and gender (Boehnlein 2001; Lopez and Guarnaccia 2000). These dynamics may not be fully captured or addressed by the tools available to population-level approaches, and call for forms of research and intervention that can help adapt standardized, “evidence-based” practices to local realities. Even more important would be to move beyond “adaptation” to the generation of locally relevant evidence to inform best practices and intervention strategies.

Social Suffering and Local Expression of Distress

Particularly anthropologists, but also increasingly psychiatrists and psychologists, criticize the usefulness of diagnostic categories such as PTSD as they fail to capture not only structural conditions and inequalities (along the lines of, e.g., poverty, ethnicity, gender, and education) but also cultural expressions of distress and the ways in which they both compromise and enhance well-being and mental health (Tol et al. 2010). Moreover, critics argue that clinical labels can obliterate the rich and urgent personal, social, and political meanings of suffering.

Byron Good (1977) was among the first to argue that it is crucial for clinical medicine to gain a better understanding of the way in which psychosocial and cultural factors affect the incidence, course, experience, and outcome of disease. According to him, disease cannot be simply considered a natural entity but is a social and historical reality, in that it becomes a medium for negotiating transformations in life context. Ware and Kleinman (1992) note that over time, these "passively received and actively negotiated changes become interspersed to form a chain of illness-related interpersonal events and processes that is also an integral part of illness's 'social course'" (p. 548). Thus, the anthropological perception of the "social course" of illness encompasses two meanings: (1) aspects of the social environment influence the severity of symptomatology (a "sociosomatic" approach), and (2) symptoms themselves shape and structure the social world. Accordingly, there exists an ever-changing dialectic relationship between the experiences of individuals and the society they live in.

Social Suffering

This insight led medical anthropologists to introduce the concept of "social suffering" to anthropological and medical discourses. Kleinman et al. (1997) define social suffering as "human problems that have their origins and consequences in the devastating injuries that social force inflicts on human experience." That is, "social suffering results from what political, economic, and institutional power does to people, and, reciprocally, from how these forms of power themselves influence the responses to social problems" (p. xi). Suffering as a social experience takes place in three interconnected spheres as it is, at the same time, an interpersonal engagement with pain and hardship in social relationships, a societal construction that serves as a cultural model and moral guide of and for experience, and a professional discourse that organizes forms of suffering as bureaucratic categories and objects of technical intervention (Kleinman 1997).

The story of one of Locke's Bosnian interlocutors, encountered in 2008 in the offices of a small Sarajevo psychosocial support NGO called Horizons of Hope (a pseudonym), captures these intersecting social dimensions of suffering in a post-war context. Emir, a thin, graying man in his sixties, regularly brings his adolescent daughter Džana to lessons and creative workshops at the NGO's offices and waits there quietly with coffee and cigarettes. Emir has three children altogether with his wife: Džana, a 20-year-old son, and a 22-year-old daughter studying economics at the university (with the help of a small scholarship from a war veterans' association). Aside from the scholarship, the family's only income is the veteran's pension—300 marks per month—that Emir receives from the state.

Emir and his family are originally from Zvornik, a town on the Bosnian side of the Drina River, which forms Bosnia's eastern border with Serbia. Zvornik was brutally "cleansed" of its non-Serb population by Serb forces very early in the war. Emir and his family managed to leave in the nick of time; they lived for a while in Croatia before his wife and children were received as refugees in Pakistan. Emir fought with the Army of the Republic of Bosnia-Herzegovina throughout the conflict. He lost hearing in one of his ears when a shell landed next to him in a trench.

After the Dayton Accords ended the war in Bosnia in 1995, Emir's family returned from Pakistan and they lived for seven years in a tiny basement apartment in a Sarajevo suburb. He got a job working as a locksmith—his trade before the war—for a Slovenian-owned grocery store chain. He was paid around 350 Bosnian marks a month, which barely provided enough to pay basic bills and provide necessities for his family. For Emir, the day-to-day "struggle for subsistence" (a phrase he used often) and to provide for his family on a meager income would have been much more bearable were it not compounded by a persistent sense of alienation and disconnection from his adopted community, neighbors, and co-workers. Faced with urban resentment of rural refugees, Emir "felt like a stranger" in his own country. The impossibility of finding support and empathy—both in bureaucratic institutions and in social relations—was a constant theme in the stories he told about post-war life in Sarajevo. Emir felt this callousness as a grave injustice, a wound more painful, even, than his wartime experiences or the hard facts and choices of poverty:

> In the war I only had one goal: to keep my head, to survive. Just that. But now it's a fight with bureaucracy. A fight for my family and for financial subsistence. Back then we lived off humanitarian aid, this and that. You know how it was, would you or wouldn't you have food.

Emir said directly that life is harder since the war than it was during it:

> OK, during the war I didn't have my family, now I have to worry about them.

For Emir, this meant constant wrestling with cold and recalcitrant state institutions simply to sustain the basic conditions of day-to-day existence. Necessities keep getting more and more costly: heat, gas, electricity, food staples:

> I simply think that politicians only worry about themselves, about their own position, their own personal interests. The people don't interest them.

He follows war crimes trials taking place locally as well as proceedings at the International Criminal Tribunal for the former Yugoslavia (ICTY) in *The Hague*, in part because one of his brothers is among the thousands of missing people presumed murdered in concentration camps or mass killings. Another brother was severely wounded when a shell fired by Serb forces landed in his apartment, and later died undergoing surgery. Emir's niece, the granddaughter of his sister, was captured and held in a rape camp at the age of 15.

> "I can respect Serbs, Croats, Muslims, it doesn't matter to me," Emir said.
>
> "I respect all good people. But I do not respect nationalists."

Asked how he wished life and the way things work in post-war society would change, Emir responded:

> I'll tell you that I was a big optimist during the war. I was so optimistic that many things would be resolved, that things would be better, that everything would be fair for the people, and so on. But after the war I was so disappointed because of this bureaucracy. So disappointed, I went to the mental health clinic. They told me to contact a psychologist. That psychologist sent me to the psychiatrists at [the local psychiatric hospital]. So I go there once every month or two to talk.

But not just to talk: Emir visits psychiatrists for prescriptions:

> I must take some pills to calm down, really because of all that, the bureaucracy, the struggle for subsistence.

Emir's use of psychopharmaceuticals, it seems, is more about making the anxiety and frustration of his post-war life more endurable than about coping with strictly *posttraumatic* stress. Emir's story illustrates core aspects of the intricate interrelations of social and subjective experience that the notion of "social suffering" is intended to capture. We see the ways in which the near- and long-term mental health sequelae of experiences of societal violence are complexly conditioned by and reflective of deeply felt socioeconomic, cultural, and political dimensions of the post-war context, from war crimes trials in The Hague and the corruption of nationalist politicians to the indifference of neighbors and the presence of nongovernmental organizations offering services unavailable through a dysfunctional state. Psychosocial organizations like Horizons of Hope often find that to best serve families like Emir's, they must expand their services beyond psychiatric consultation and counseling to include broader and more ad hoc forms of social support (Locke 2009).

Idioms of Distress

In addition to "social suffering," the "idioms of distress" approach offers a complementary tool for discussing the ways in which social and political determinants affect individuals' and communities' well-being. The concept has been in circulation for over 30 years and was first introduced by the anthropologist Mark Nichter (1981). In a more recent article, Nichter (2010) defines the idea as follows:

> Idioms of distress are socially and culturally resonant means of experiencing and expressing distress in local worlds. They are evocative and index past traumatic memories as well as present stressors, such as anger, powerlessness, social marginalization and insecurity, and possible future sources of anxiety, loss and angst. (p. 405)

He goes on to explain that when idioms of distress are experienced along with significant pathology, they express personal and interpersonal distress beyond that associated with universal disease processes.

Local idioms of distress are polysemic and idiosyncratic phenomena that bridge and transcend somatic, psychic, and social phenomena (Davis and Joakimsen 1997; Lock 1993; Sapkota et al. 2014). Since its first introduction into academic discourse, the concept of idioms of distress has become a self-explanatory term that is used to make sense of cultural categories as diverse as *nervios*, *susto*, *llaki, ñakary*, *ihahamuka*, *open mole, khyâl attacks* and so on (Abramowitz 2010; Hinton et al. 2010; Pedersen et al. 2010). For example, Hagengimana and Hinton (2009) describe the Rwandan idiom *ihahamuka*, which literally translates into "without lungs" and has been the most common presentation of traumatic distress since the genocide in 1994. Its main symptoms are shortness of breath, pain, and heat in the head. Catastrophic cognitions about this shortness of breath, which carries iconic resonances, are a key feature. *Ihahamuka* is thus connected simultaneously to traumatic personal experience, bodily experience and somatic symptoms, and social processes including ritual action, metaphor, ethnophysiology, and symbol.

In a different context, Kienzler (2010, 2012) investigated the lived experience of social inequalities and cultural idioms among Kosovar Albanian women in post-war Kosovo. She found that women often expressed their distressing memories and thoughts through folk diagnostic categories such as *nervoz* (nervousness) and *mërzitna* (worried, sad), which could not be distinguished based on the symptomatology but rather in relation to particular emotions and the context in which they were expressed. Women often said that they only become *nervoz* about matters that are important to them such as memories of the war and the related grief, the burden of widowhood and the overwhelming responsibilities that go along with it, economic problems and the fears of not being able to provide for their children and anger due to interpersonal conflicts. Widows explained that *nervoz* resulted from the enormous responsibility of being "the man and the woman of the house" at the same time, having to provide an income for their family, entering into competition for the humanitarian aid delivered to their village and dealing with the gossip that usually resulted from this. *Mërzitna*, on the other hand, is the popular version of the word *mërzitem* and translates into to be sad or worried. The idiom is associated with compassion and helplessness. While both emotions are interrelated and tend to occur at the same time, they differ in their intensity depending on the context and, in many cases, whether a person is sad or worried.

Discourses on sadness often referred to a sense of loss and loneliness in the context of war, the death of a family member or friend, or husbands and children moving away from home to work abroad or to study in the city. This is illustrated by the story of an occasion when Kienzler met Fitore on her compound to buy detergent that she had bought in bulk to resell in order to make some money on the side. She looked tired and worn out. Leaning against the anthropologist's car, she said that she could hardly sleep last night and that her entire body was hurting. She sighed:

> I am *mërzitna,* that's why every bone in my body hurts.

When asked why she felt *mërzitna*, she explained that she had given an interview to Polish humanitarian aid workers the day before that had reminded her of past hardships:

> The Polish women are in Kosova for only four days and try to talk to as many women as possible. The interview lasted for two hours and was all about the war and the way I coped without my husband. I wasn't prepared for it and, before I knew it, war memories awoke inside me.

Discourses on the notion of feeling worried were usually very compassionate in that worrying about someone else's health and well-being brought on feelings of sickness. This, in turn, accentuated a positive image of the women as they talked about their psychic and somatic symptoms within the context of their deeper concern for family members.

In sum, idioms of distress, expressed through a wide range of illness symptoms, served as mostly somatic references to multiple causal connections, including memories of war and post-war hardship, poverty, widowhood, sanctions against remarriage and divorce, restrictions on leaving the in-law's compound, and interpersonal conflict, gossip, and jealousy. To reduce them to "mental disorders" would be too simplistic as they also involve elements of societal critique, which particularly village women often cannot voice in the public arena due to their position in a strongly patriarchal society. Thus, a greater focus on idioms of distress could emphasize the agency of individuals in establishing social networks and drawing attention to the lack of support and other societal ills.

Concluding Remarks

Violence in its many forms is pervasive, ancient, infinitely various, and a central fact of human life, but also poorly understood in general (Whitehead 2004). In this chapter, we have introduced different approaches that aim to provide a better understanding of the consequences of violence from various angles, focusing on its communicative role, symbolic use, performative quality, and lived experience. We have shown that violence in contexts of war has been linked to physical and, particularly, mental health problems. A strong focus on PTSD and depression based on Western diagnostic practices has largely shaped the response to trauma-related health problems leading to the development of different kinds of trauma-focused responses ranging from psychotherapies to various pharmaceutical interventions. However, critical scholars have shown that such approaches lack evidence on their long-term effects and demonstrate that mental health problems are intricately connected to social, economic and cultural dimensions of life. Such recognition has complicated our understanding of the causation, development, and treatment of violence-related distress.

Having a better understanding of the ways in which individuals and communities express their suffering and distress and the influence this has on their lives could help health providers to tailor therapeutic interventions more effectively to the needs and expectations of their patients. There is a great danger of over-medicalizing or over-psychologizing forms of post-violence distress, which are complexly overdetermined by the socioeconomic, political, and cultural dimensions of post-conflict societies. Anthropologists have shown that interventions that attempt to address health—and especially mental health—without engaging with these social determinants often fail to deliver aid that is meaningful to the intended beneficiaries, and can even cause unintended consequences insofar as they pathologize victimized populations and distract from substantive issues of restorative justice and political reform (Biehl and Locke 2010). While one-size-fits-all technoscientific or medical solutions to the social and personal consequences of societal violence may be elusive, the subjects of interventions reveal that we may have much to learn about the determinants of their suffering—and their resilience—before we can begin to deliver forms of care and support that are truly multidimensional and thoughtfully adapted to cultural difference. Ethnographic methods, with their commitment to cultural humility and deep forms of listening, surely have a central role to play in this process.

We do not deny that trauma-focused approaches have their place in the complex process of healing the psychological wounds of war and violence, but suggest that alone they are not sufficient and may lead to important unintended consequences. It is important to be attuned to the fact that suffering as well as recovery are resolved in a social context as "familial, sociocultural, religious and economic activities (…) make the world intelligible" (Almedom and Summerfield 2004, p. 386). With this understanding, trauma-focused approaches could possibly be reserved for very severe cases of mental illness while other forms of distress could be addressed meaningfully through locally developed (bottom-up) and socially integrated approaches addressing the often difficult to grasp combinations of social, emotional, physical, and cultural dimensions. This, in turn, can only be achieved through interdisciplinary approaches in which clinicians and other interventionists work closely with researchers from the health and social sciences. In the decades to come, it will be crucial to build connections across health, social welfare, education, and economic sectors while paying close attention to cultural and religious beliefs and practices in order to address the effects of societal violence on bodies, minds, and societies more effectively.

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15

Medical Pluralism and Global Mental Health

David M.R. Orr and Serena Bindi

One of the foundational concepts of the field of Global Mental Health (GMH) is the notion of the 'treatment gap.' Defined as 'the percentage of individuals [affected by mental disorder] who require care but do not receive treatment' (Kohn et al. 2004, p. 859), it has been prominent in the agenda of GMH initiatives ever since. Yet it has been pointed out that this 'gap' is not in fact characterised by an absence of treatment but rather by a host of forms of treatment that are not easily recognised within the standard frameworks employed within GMH, based around the criteria for 'evidence-based' interventions. Many of the treatments accessed by individuals and families coping with mental disorder are not part of the official, predominantly biomedical, mental health sector (Burns and Tomita 2014; Sorsdahl et al. 2009; World Health Organization [WHO] 2013). This reflects the reality that contemporary societies worldwide, including both high-income[1] and low- and middle-income countries (LMICs), are characterised by medical pluralism. Medical

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[1] Complementary and Alternative Medicine (CAM) is the obvious—though not the only—example of this, where the therapeutic options on offer in high-income countries often seem to take their inspiration from the very regions consigned to the 'treatment gap' (e.g., Ayurvedic healing from India and shamanic healing from several regions of the globe).

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pluralism describes situations where people may choose—or, particularly in mental health (where mental capacity to make decisions may be called into question), may often have choices made for them—from a range of coexisting therapeutic options. A sizeable proportion of mental health consultations occur not with biomedical doctors and allied professionals, but with complementary and alternative medical practitioners, traditional healers, herbalists, religious figures, 'lay' experts and a range of other followers of distinctive therapeutic approaches. Acknowledgement of this reality calls on GMH to consider the challenging and diverse territory of medical pluralism and to engage with the questions that it raises.[2]

Extensive research exists charting the choices people make between healers within plural medical landscapes. Though we touch on this where relevant, we are not seeking in this chapter to provide a comprehensive summary of this literature. Rather, our main focus is to examine aspects of how GMH, as formulated by some of its prominent scholars and advocates, relates to some of the alternative forms of healing with which it comes into contact. We first provide a condensed account of how the study of medical pluralism developed in the social sciences over time. We then discuss the problematic classification of 'traditional healing' and cognate healing approaches and outline their relevance for GMH. Having set out this background, we go on to explore three key issues shaping the interactions between GMH and other forms of healing: (1) the epistemologies, explanations and experiences that come to define mental health issues, (2) questions of the effectiveness of healing approaches and (3) power and politics within healing.

Studying Medical Pluralism

It is instructive to look at the history of how medical pluralism has been studied, as the paradigm has undergone refinements over time. Charles Leslie's (1976) pioneering work first brought medical pluralism under the microscope for systematic study and introduced the concept of 'medical systems,'

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[2] In any chapter of this length, it is impossible to capture the breadth and variety of global practices and philosophies implied by the term 'medical pluralism.' Faith healers within a range of different religious traditions, empiric herbalists, shamans, acupuncturists and a host of others, who practise with varying degrees of independence, regulation and professionalisation, could be considered. For any tentative generalisation that it is possible to make about forms of healing in one country or culture, counter-examples from elsewhere (or exceptions from the same setting) could be found. The approach we take is therefore to survey issues and principles with brief reference to examples, rather than going deeply into specifics; we beg readers' indulgence where this has meant apparent over-simplifications or excessive generalisations.

an analytic framework that was to prove hugely influential for many years. Though Leslie originally wrote of biomedicine, Ayurveda, homeopathy and so on as ‘subsystems’ within one holistic greater ‘system’ (each of which generally corresponded to a ‘culture’: Indian, Chinese, Japanese etc.), later work more commonly classified each distinctive body of practitioners within a community as a ‘medical system’ in themselves (Johannessen 2006, pp. 3–4)—hence biomedicine constitutes one system, churches offering religious healing constitute another, shamanic healing constitutes another and so on. Such classifications provided a foundation for comparative work that explored cultural, social and cognitive influences on decision-making about how to prioritise different healing systems in the search for help (in Romanucci-Ross’ [1969] memorable phrase, the ‘hierarchies of resort’ that the sick and their families employed) and the structural factors that made one healing profession dominant or subservient in relation to others. Interpretive-symbolic approaches sprang up that centred on the meanings inherent to healing traditions, while structural—and later critical—approaches examined the political economy of, and social barriers to, use and expansion of the same traditions (Baer 2011).

Yet from early on, there were difficulties with the notion of ‘systems,’ or at least with the way it was used in medical anthropology. Last (1981) questioned how helpful ‘systematisation’ really was, suggesting that very often the kind of organised theory which Leslie envisaged as structuring a coherent ‘medical system’ might, on closer investigation, often be missing. In fieldwork in northern Nigeria, he observed that this lack of a coherent underpinning seemed to be of little concern to either healers or those who consult them. His resulting notion of ‘non-systems’ anticipated later critiques of the systems approach to medical pluralism, as it became more and more obvious that help-seekers commonly resort to different kinds of healers without experiencing any evident contradiction. In doing so, they may classify these healing options as belonging to distinct categories or they may see them as simply diverse options, without framing them as part of specific ‘systems.’[3] Moreover—contrary to the assumptions that inform policy approaches to traditional healing such as that of the WHO—healers themselves may sometimes not see their practice as operating within a particular ‘system.’ Just as much as biomedical practitioners, their concern is often with ‘what works’ and, as Last (1981) found, understanding how it fits together may be of little concern to them. Indeed, the very potency of traditional healing may come from its status as unknowable or from how it draws on a multiplicity of cultural resources

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[3] Indeed, the understudied but common phenomenon of self-medication (Ecks 2014, p. 176) indicates how unconcerned people may be with the ‘system’ underlying their treatment.

(West and Luedke 2006, p. 11). Some may be selected for the allure of novelty or innovation, rather than for their established position within a tradition. A focus on systems, then, at times has led researchers to neglect the perspectives of both healers and help-seekers.

Even in settings where conceptualising healing in terms of 'systems' more accurately reflected local perceptions, there remained a further problem. The use of typologies based on discrete, internally consistent therapeutic systems usually failed to account for the extent of interaction, mutual influence and 'crossing' between them, as elements of practice are absorbed or selectively adopted across supposedly distinctive approaches. In addition to the thriving cross-pollination between practices considered to be 'traditional healing,' ever more marked effects of biomedicine on the practice of traditional medicine can be detected in many places, as either selected features are incorporated into traditional healing techniques and symbolism (Greene 1998; Lang and Jansen 2013) or traditional healers adapt their approach to differentiate themselves more clearly from biomedicine (Halliburton 2009, p. 180); more rarely, influences from other forms of healing spill into biomedical practice (Langwick 2008; McMillen 2004).[4] Consequently, reified notions of distinct healing traditions are now more rarely taken for granted within the social science literature; researchers have increasingly come to emphasise therapeutic hybridity, 'borderlands' and 'networks,' and medical 'practices,' 'cultures' and 'landscapes' are more commonly discussed than 'systems' (Baer 2011, pp. 419–420; Johannessen 2006, p. 4; West and Luedke 2006).'[5] Rather than assuming that there are boundaries that help-seekers decide when and how to cross, scholars now pay more attention to the discourses people use in constructing those very boundaries and classifications.

These developments have caused shifts in understanding of what the 'pluralism' within 'medical pluralism' refers to. Rather than comparisons between a defined number of discrete, internally coherent 'systems,' emphasis is now placed on following the manifold ways people find to make sense of the fractured, overlapping or contradictory therapeutic options available to them, with rather less regard for consistency than social scientists had initially supposed. In addition to the concept of 'pluralism,' the adjective 'medical' has

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[4] The field of mental health has arguably been more receptive to this than other biomedical specialties, with understanding derived at least partially from traditional healing featuring heavily within the various strands of cultural and ethnopsychiatric approaches and even receiving some limited acknowledgement in the Fourth and Fifth Editions of the American Psychiatric Association's *Diagnostic and Statistical Manual* in the form of the 'Glossary of cultural concepts of distress.'

[5] These developments mirror the adoption in the social sciences of similarly nuanced ways of discussing 'culture,' as it has become increasingly difficult to maintain the fiction of distinct, internally consistent 'cultures' that can be somehow separated out from each other and made to stand apart.

also been questioned; it implies that problems seen as 'medical' issues in one frame of reference will or should also be seen as medical issues within other frames. This may not always be the case (Kapferer 1988); some areas of mental health, as it is defined by biomedical psychiatry, may instead be seen in spiritual, social or other terms and may sometimes be more appropriately treated as such. This medicalisation argument has formed the basis of fierce attacks on GMH (e.g., Mills 2014; Summerfield 2008). GMH advocates have responded by arguing that it is possible to find a balance between universalist mental health frameworks and local understandings, and that a mental health approach, provided it is informed by engagement with community development, need not entail misrecognition of culturally validated realities (Patel 2014). The debate is played out in depth throughout this volume; for the purposes of this chapter, it suffices to observe that the analysis of plural forms of healing may not be a simple thing, when even the terms of the comparison are not always straightforward to define. This is an issue that we will explore further in later sections.

Traditional Healing and Global Mental Health

Though medical pluralism covers the entire range of therapeutic options available within a society, much of the published research with relevance to GMH has been carried out with what is commonly called 'traditional healing' or 'traditional medicine.' This is defined by the WHO as:

> 'the sum total of the knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health, as well as in […] prevention, diagnosis, improvement or treatment […].' (2013, p. 15)

Though estimates of the extent to which traditional healers are sought out for help with mental health problems vary widely (Burns and Tomita 2014), forms of traditional medicine—alongside religious healing, which in many settings overlaps considerably with traditional healing—represent a widespread counterpart to GMH models in many LMICs. It will be apparent that the scope of 'traditional medicine' or 'traditional healing' is broad, and in many ways the label is problematic. For many, it connotes static practices that persist unchanged through time, which is at best a partial or inaccurate picture of the dynamism and flexibility that many healers employ in developing and adapting their approaches to changing circumstances and illness challenges.

Furthermore, the WHO's emphasis on 'indigeneity' ignores the cross-fertilisation that permeates healing practices. For example, whether a Peruvian shaman who incorporates hypodermic needles into his own healing rituals (Greene 1998) neatly meets this definition is difficult to determine and probably a question of little interest to either him or his clients. 'Complementary' or 'alternative medicine' are other terms sometimes used; these too are only partially satisfactory, given their implication that a specific dominant model (usually biomedicine) is the norm which other approaches 'complement' or to which they are an 'alternative.' While this may be the case in many societies and spheres of health care, it is far from being universally applicable. However, no alternative label has yet gained widespread acceptance. For all that the difficulties with the term 'traditional medicine/healing' are widely acknowledged, it remains the term of choice within the WHO, GMH and much anthropological literature. In the absence of a clearly suitable alternative, we have opted to use it in this chapter while acknowledging and highlighting its limitations, as this seems to us to best reflect and engage with common scholarly and policy usage.

The GMH movement has inherited a complex relationship with traditional healers in LMICs, where the treatment gap is considered to be most evident. There is a history of seeking to work with and incorporate traditional medicine within the major international health institutions, dating back to the 1970s. A strategy of integrating traditional healers into primary health care was endorsed at the 1978 WHO–UNICEF meeting at Alma Ata (WHO 1978). Though the degree to which member states embraced the role of traditional healing in the intervening years has varied enormously,[6] there is still support for selected elements of it in policy today, as the development of the *WHO Traditional Medicine Strategy 2014–2023* (WHO 2013) testifies. GMH researchers too have on several occasions recognised the potential value for mental health of collaboration between biomedical services and traditional healers (e.g., Abbo 2011; Burns and Tomita 2014; Patel 2011). In particular, they note that traditional healers could constitute a vast army of informal or semi-formal practitioners who are already known and consulted, thereby strengthening links with communities and easing access to biomedical mental health services for those in need.

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[6] It is worth noting that—apart from the use of traditional healers in screening and referral roles—the focus of many efforts was primarily ethnopharmacological, driven by the idea that the plant-based knowledge held by traditional healers could be mapped and refined for use in alliance with biomedicine; practices and cosmologies that might accompany, encompass or substitute for herbal lore were often downplayed or dismissed.

However, it is also common for GMH activists to take an adversarial standpoint in relation to traditional healers. Biomedicine has historically tended to define itself against ‘quackery’ and ‘charlatanism’ (Wahlberg 2007), and GMH has to a large extent followed in this tradition. Hence Vikram Patel, notwithstanding his suggestion of openness to the possibility of collaboration with traditional healers, memorably revised notions of the ‘treatment gap’ as the *absence* of treatment by declaring that:

> We shouldn’t assume that people aren’t getting treatment. They are getting treatment, but they are getting the wrong treatment. (Patel, cited in de Menil and Iemmi 2014)

Similarly, Alex Cohen has pointed out that medical pluralism may in practice lead to little more than ‘a continuous sampling of ineffective cures offered by charlatans’ (2014, p.329). Critiques in this vein draw attention to the failings of traditional healing in respect of both scientific evidence and human rights (Doku et al. 2011; MDAC/MHU 2014; Patel and Saxena 2014). Certainly traditional and religious treatments sometimes violate human rights (as indeed do psychiatric treatments). More commonly, concerns are often expressed that initial consultations with traditional healers may lead to delays in accessing ‘appropriate treatment,’ resulting in unnecessary suffering and potentially worsening the prognosis (Burns and Tomita 2014; Egbe et al. 2014) or eating into scarce family funds for care (MDAC/MHU 2014). It can be challenging for biomedical practitioners to tolerate, let alone work meaningfully with, traditional healers when—despite professing to observe cultural sensitivity—they feel, as many do, that ‘interventions should not perpetuate what are regarded as “unscientific” or “superstitious” beliefs and practices’ (Nuffield Council on Bioethics 2002, p. 74; see also Ae-Ngibise et al. 2010). From this standpoint, traditional healers are inherently an obstacle to the achievement of global mental health, rather than a potential resource.

Key Issues in Medical Pluralism

GMH and psychiatry have thus at different times either engaged with or attacked traditional healers, but they have rarely been neutral. A number of factors potentially influence how their interactions unfold as collaboration, competition or clash. Here we consider three. The first is ‘epistemology’ (the approach to knowledge favoured by different healing approaches) and how the paradigms underlying GMH and traditional healing bear on the explanations and experiences emerging from help-seekers' encounters with healers. We then offer an account of how features of effectiveness may be conceived differently between paradigms, highlighting some of the complexities of this question but also some of the dangers. Finally, consideration is given to how power and politics impinge on the interactions between healing practitioners and institutions, and between healers and their clients.

Epistemology, Explanation and Experience

GMH and traditional healing are generally considered to be characterised by contrasting epistemological frameworks. GMH's favoured 'way of knowing' derives from Evidence-Based Practice (EBP) (Thornicroft and Patel 2014), which promotes the use of rigorously operationalised empirical methods—mostly Randomised Controlled Trials, meta-analyses and systematic reviews—in building a research base that should guide professional practice in medicine and related disciplines and guard against the influence of practitioners' unfounded habits, cognitive biases or vested interests in particular therapeutic methods. By contrast, traditional healing—or at least its ritual forms—has been referred to as 'the original non-evidence-based medicine' (Sax 2014, p. 831). While many traditional healers value empirical observation, they are not usually afforded the opportunity to carry it out on a systematic scale, and intuition, spiritual revelation or divination may be at least as important for them as testing out results. In absolute contrast to EBP, West and Luedke (2006, p. 11) note that some traditional healers are actually highly reluctant to 'know' very much about the potentially dangerous spiritual forces that they draw on or reckon them to be unknowable. The diversity of practices, styles and bodies of knowledge to be found within traditional healing are not easily captured by approaches operating within the methodological assumptions of EBP, which potentially marginalises or invalidates epistemologies that do not conform to mainstream psychiatric and psychological models of mental health (Kirmayer 2012). For example, trials of therapies for depression already assume the validity of a particular diagnostic perspective that tends to locate a problem within an individual, rather than in social relationships or socio-economic hardships. Alternative epistemologies that give greater prominence to the role of social factors, to say nothing of those that emphasise the relationship between humans and the spirit world or rely on different conceptions of personhood, are more rarely incorporated and tested within an EBP model. Though it may in some circumstances be possible to imagine doing so, dominant epistemologies exercise very real constraints over what is prioritised and tested within GMH and on what terms this is done (Orr and Jain 2014).

These limits have led to calls for greater 'epistemic pluralism,' which is suggested will in turn lead to 'methodological pluralism' and 'new forms of political recognition and engagement' (Kirmayer 2012, p. 254). Leading figures in GMH have shown themselves willing to engage with this agenda to a degree, as demonstrated by the insistence on identifying the movement with 'mental health' rather than primarily with 'psychiatry' and its associated epistemologies (Whitley 2015) and the further links it has sought to forge beyond standard mental health paradigms, notably with development studies (Patel 2014). Increasing use of realist evaluation of complex interventions is to some extent counterbalancing simplistic interpretations of biomedically based EBP, though it remains to be seen how far the commitment to 'scaling up' interventions (Whitley 2015, p. 3)—with its basis in generalisable principles and interventions—can engage with the diversity of epistemologies and cosmologies that may be present within a population.[7] Indeed, many would question whether GMH even should, for fear of casting aside the undeniable benefits that EBP has brought to medicine, for what Kirmayer calls 'an epistemological melée in which anything goes' (2012, p. 253).

Views differ on how much these grand theorisations of epistemology affect what healers actually do in practice. Patel (2011), for example, argues that the contrast between the epistemologies of GMH and those of other forms of healing has been exaggerated. Pointing to evidence that Ugandan traditional healers identified similar patterns of symptoms as did psychiatrists, he suggests that the paradigms may not always in fact be especially different in use, as opposed to in theory. However, his interest in exploring whether traditional healers might be enlisted for a screening and referral role to psychiatric services means that he gives less attention to differences in the interpretation given to those patterns and in how healers approach resolving the presenting problems. A number of researchers have argued that these are the key aspects where commensurability between the values, assumptions and ways of knowing about the world of healer and client is essential for any kind of serious success. Sax (2014) points to significant issues for Western-derived mental health therapies in India, stemming from how the 'individual' is understood; he suggests that individualisation (self-realisation), rather than being the goal of healing, may instead be seen as constituting the very problem to be resolved.

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[7] Kirmayer (2012) argues that even the wealth of research available on mental health in the USA neglects the extent of cultural diversity there and bases its studies on samples that do not reflect the general population. It seems likely that the much smaller volume of research on mental health in LMICs suffers from the same issue (Orr and Jain 2014).

Calabrese (2008) has raised related issues from his clinical/anthropological work with the Native American Church, where he found that profoundly different orientations to epistemology, sociality and spirituality were at the root of a cultural clash which greatly attenuated the success of standard Western psychotherapeutic treatments and made the value of traditional healing methods undeniable. These ethnographic studies suggest that at least some cases and settings call for a broader, flexible approach to what might constitute appropriate forms of EBP. Indeed, Halliburton (2004, 2009) has argued that best outcomes are actually facilitated by greater plurality of therapeutic principles among available healing traditions. He suggests that pluralism is worth preserving precisely because it allows individuals and their families to explore and find the best match among the treatments on offer, bringing into question the approach of EBP and growing attempts to standardise traditional medicine (see Sax 2014; Ranganathan 2014). A cautionary note is sounded by Jacorzynski (2006), reminding us that plurality of therapies might also have negative effects. Jacorzynski's account of an individual case of mental disorder in Chiapas, Mexico, raises the question of whether the availability of multiple interpretive frameworks is always helpful, or whether it might sometimes present a bewildering epistemological maelstrom in which the client, feeling buffeted by the competing views of the healers and those around him or her, is unable to find firm footing. Caregivers too may be looking for authoritative judgement, not uncertainty and diversity of views.

The extent to which reaching an 'understanding' of the problems in question actually matters for help-seekers' choices among medically plural options—and its implications for therapeutic communication—has also been much debated. Burns and Tomita (2014) report that studies in parts of Africa suggest traditional practitioners are considerably more likely to provide people consulting them with an explanation of their situation than mental health practitioners, who may prioritise treatment over communication. They suggest that a possible reason why the traditional healers are often more consulted than the mental health practitioners lies in this attention to providing help-seekers with a framework for understanding.[8] Other authors feel that there is an overemphasis in the research literature on help-seekers' explanations which amounts to 'scholastic fallacies' (Quack 2013, p. 403); they argue that most people are relatively unconcerned with understanding what a condition is or what caused it and simply want to know if a treatment works. Where mental health problems are complex and difficult to resolve entirely in a short space of

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[8] Not all traditional healers share this concern to provide diagnoses or explanations, with some (e.g., Q'eqchi healers in Guatemala) affording it little priority at all (Waldram 2013).

time, it is often likely that people may feel the need to find some satisfactory way of understanding what is happening. However, any search for meaning is unlikely to continue indefinitely if it does not seem likely to lead to pragmatic results (Benoist 1996), which brings us to the question of effectiveness.

Effectiveness

The effectiveness of treatments seems at first sight a straightforward matter of measuring symptoms, everyday functioning, participation in meaningful activity or other observable aspects of the person's life, and indeed, this approach has proved beneficial in many areas of mental health. Yet it has not prevented ongoing disputes over whether, and to what extent, diverse forms of traditional healing are actually effective, claims and counterclaims abound. Although forms of traditional healing are being incorporated alongside mental health services in a number of settings, this has rarely been preceded by the same kind of evaluation to which biomedical and psychological treatments are generally subject, a fact which sometimes makes it hard for practitioners working within these models to accept them fully (Ae-Ngibise et al. 2010). In the light of GMH's interest in how it might work with (or against) other healing traditions, it is important to give thorough consideration to the factors that complicate measuring effectiveness in this area.

Researchers have proposed a range of theories to explain the mechanisms of efficacy of traditional healing forms that rely on 'procedural,' as opposed to ethnopharmacological or directly physical, approaches. Lévi-Strauss (1963) initiated one line of theorising when he compared the shamanic practices of the Kuna indigenous people of Panama to psychoanalytic therapy in that they provide symbols, a language and a framework through which the person experiencing distress or illness can understand his or her situation, and thereby spark the healing process. Desjarlais (1992), by contrast, argued that the emphasis on cognition implied by symbols and understanding is misleading and that traditional healing is often as much about the movements, aesthetics and bodily experience of ritual. He describes how Nepalese shamans call on those they treat to 'perform' the movements and plot of ritual while in a trance state, presenting gestures, images, scents and sounds to 'touch all the parts of the body' (ibid., p. 222) and rouse them from their emotional and spiritual distress. It is through a culturally meaningful sensory, visceral experience, and not at a purely symbolic level, that they find their health improved. Halliburton (2009) similarly argued that the sensory aspects of treatments ('feel,' taste, appearance and pain/comfort) may play a role not just in people's choices between healing options but in the determinants of healing success. Persuasion, narrative, placebo and social support are among other mechanisms explored in the literature on ritual healing (Sax 2014, p. 833). But this attention to *how* traditional healing works has overshadowed the question of *the extent* to which it works (Waldram 2000, 2013). A number of obstacles to adequately answering this question are identified in the literature.

The first of these is that it may be problematic to identify the goals to which attempts at healing are addressed and thus against which effectiveness should be measured and compared. The kinds of transformation sought by traditional healing may correspond to elimination of symptoms as is common in biomedical approaches, but this should not be assumed *a priori*; sometimes alternative or 'deeper' changes are envisaged by healing traditions, with only indirect (or, conceivably, no) effects on the symptoms assumed by Western diagnoses to be at the heart of the problem (Sax 2014; Waldram 2000, 2013).[9] Thus Halliburton (2009) and Ranganathan (2014) have argued that part of the appeal of traditional and temple healing in India may come from the flexibility it offers; in some of these traditions, they suggest, people are supported to adjust to and live positively with their 'mental health problems' rather than having to continue with wearying regimes that seek to overcome or control those problems. This approach to medical pluralism is reminiscent of one of the key insights at the heart of the recovery model (Aldersey et al. this volume): that it is ultimately people themselves, not service providers, who best decide what goals are meaningful and what support best helps to achieve them. Western mental health approaches are increasingly becoming aware of these challenges, and one can perhaps envisage how culturally validated measures of wellbeing could be adapted to capture some of these alternative priorities and gain some measure of general agreement over their use (see Eyber and White this volume). However, such an undertaking is neither easy nor far advanced in GMH, and some question the very notion of trying to capture the diversity of effects of traditional healing under one umbrella (Sax 2014).

Second, the unit of intervention may vary. It has been suggested (Sax 2014; Waldram 2000) that the outcome sought may not always be a specific psychological change in the individual but rather that it may be the restoration of family unity or social reconciliation which might be given highest priority in many forms of traditional healing. In such situations, it is a collectivity rather than an individual who is the focus of intervention. At times giving this consideration priority in healing may raise problematic ethical questions setting the rights of the individual with mental distress against those of their relatives or community. Yet often it will likely be helpful to all parties, for as systemic

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[9] For that matter, the main goal of ritual may be the avoidance of further misfortune rather than cure.

and family therapies in the West show, quality of relationships can hence have significant effects on mental health. However, it again illustrates that the most appropriate outcome assessments can vary according to the socially and culturally determined priorities of different populations. This is particularly the case where the social reconciliation aimed for incorporates non-human beings such as spirits or gods (Sax 2014), which have little or no role in the typical ontologies of mental health practice but may be of vital significance to help-seekers and those around them (Bindi 2012).

Third, Waldram (2000) argues that deciding on a suitable timeline for determining effectiveness may encounter differences in approach between biomedical standards of evaluation and those of traditional healing. Biomedical trials must proceed by assigning a time at which expected changes should have taken place, if they are to be measured. This may or may not be the case in traditional healing; some traditions envisage a 'lifelong process' of 'recovery,' while others may anticipate a contingent and unpredictable treatment course (ibid., p. 611). That said, Western models of mental health may of course also allow for varied outcomes in severe mental disorder, ranging from 'cure' or 'remission' to chronic illness management through medication and psychological, social and behavioural strategies.

Fourth, the measurement and comparison of effectiveness may be challenging. Trials should in theory compare standardised, rather than variable, practices, if they are to produce accurate results. This calls for a 'normalising' approach to the traditions under evaluation. But amidst the 'Babel of idioms' (Sax 2014, pp. 842–843) at play in much traditional healing, this is difficult. In contrast to biomedicine's emphasis on singular forms of 'best practice,' in many cases traditional healers often derive their appeal from the distinctiveness of their approaches (Orr 2012) or from inherently unstandardisable factors such as the closeness of their relationship to a spiritual entity, which will differ from one healer to another and may anyway fluctuate dramatically over time. Spirits within many traditions can be capricious, and practices such as ecstatic trance do not lend themselves to such features of trials as quantifiable exposure to a constant, predetermined dosage (Sax 2014, p.842) or procedural guidance from a manual.

Because of these complexities, Waldram (2013) has argued that any efficacy studies of traditional healing should start by exploring from the perspectives of all stakeholders (patients, caregivers, healers, community members and researchers) the issues such studies are to address. Only by doing so, in his view, does it become possible to aim at the 'moving target' (ibid., p. 619) of efficacy while minimising the 'temptation to make efficacy studies easier by arbitrarily anchoring them in a specific culture, time, place, or situational context' (ibid., p. 620). This seems good advice. While it allows researchers to guard against biomedical bias, by putting help-seekers at the heart of the research it may equally overcome the converse bias: functionalist tendencies evident in much of the literature which assume that because traditional healing persists, those who consult it necessarily accept its claims to efficacy 'in principle' even when it fails to heal them in practice. Help-seekers may indeed conceive of effectiveness in broad and multiple ways, but they are rarely averse to pointing out when traditional healing fails to live up to its promises and delivers only a constantly postponed or inadequate healing (MDAC/MHU 2014; Orr 2012). This is not to deny that healing may often be effective but rather to point out that researchers sometimes too readily assume this to be the case (cf. Waldram 2013, p. 192), raising ethical questions over whether they may be privileging the perspective of the healers over that of the people consulting them.

Some of the above objections, notably the third one (i.e., timeline), recall similar arguments—now largely lost, at least in the UK, USA and other HICs—that psychoanalytic therapies and CAM should perhaps be exempted from standardised evaluation. Partly because of this precedent, practitioners and researchers schooled within a Western biomedical model of mental health often see such objections as merely special pleading not to be subject to the same standards of evidence that they themselves must satisfy (Ae-Ngibise et al. 2010). Patel (2014, p. 783), while open to the possibility of working with traditional healers, has condemned as racism assumptions of incommensurability between Western ways of dealing with mental disorder and those of other cultures, implying that similar standards of effectiveness ought to be applied whoever is doing the healing and wherever it is taking place. Others, such as Sax, fear the potential of this view to lead to cultural imperialism. Still others suggest that if such comparisons are done in less selective ways (i.e., ones that are not based *a priori* on psychiatric categories and assumptions), psychiatric models would perhaps compare poorly with other approaches (Mills 2014; Bentall 2003, pp. 118–145). This is a question that we do not explore in any depth in this chapter,[10] but it does serve as a useful point of departure from which to consider the next subsection: power and politics in GMH.

Power and Politics

Andrew Scull (1993), in his treatise on the eighteenth- and nineteenth-century history of madness, convincingly argued that the establishment of biomedical monopoly over the treatment of insanity in Britain was primarily due not to

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[10] See Mills & White (this volume) for more on this.

the effectiveness of the treatments doctors offered, nor to advances in their scientific understanding, but to the ways in which the profession mobilised political, legal and social pressures in its favour. The contemporary socio-historical context in which GMH is situated is clearly vastly different, but Scull's point is a reminder that developments in medical pluralism are never solely driven by evidence of effectiveness or epistemological concerns. Rather, different forms of healing sit within unequal relations of power to each other, based in large part on the social standing of their practitioners and the degree to which they manage to obtain backing from powerful institutions such as the state. As anthropological and sociological research has shown, this cannot but affect the decisions that people make in regard to them.

Scholars writing from critical perspectives have made the claim that medical pluralism 'tends to reflect hierarchical relations in the larger society' (Baer 2011, p. 412). At this point in history, biomedicine is the dominant therapeutic framework at a global level. Alternative healing frameworks are often prohibited, marginalised or co-opted under the biomedical umbrella. The latter outcome generally means the adoption of a subordinate position within the biomedical health system and may require the compromise or adaptation of fundamental principles so that they 'fit' better within their new environment. Of course, the degree to which practitioners are able to preserve their independence even under biomedical dominance will vary; Baer (ibid., pp. 415–416) gives osteopathy as an example of a practice which achieved respectable status in the eyes of US biomedicine partly by abandoning its original distinctive approach, while chiropractic work in that country remained at a remove from biomedicine and stayed closer to its roots.[11] The fear of some commentators in relation to the GMH endeavour to incorporate selected forms of traditional healing is that practitioners may ultimately lose what is most distinctive about the way they work in response to the pressures that come with the limited forms of professional recognition on offer (Sax 2014; Quack 2012).

Baer (2011) further argues that the social status of therapeutic frameworks vis-à-vis the dominant approach influences not only how their practice develops but also who enters the profession. Class, educational, gender and ethnic identity may all be implicated, and may shape the majority assumptions and overall culture of a profession. Of course individual practitioners may dissent from such norms and distance themselves from them in their day-to-day work, but nevertheless this process has been shown to exercise a powerful influence

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[11] Similar concerns regularly erupt in professions such as clinical psychology or social work that the core values of the discipline risk becoming too subjugated to the medical model. Negotiations over the relative power and positioning of any group of therapeutic practitioners are always an ongoing and dynamic process.

in several different cultural settings. It is unsurprising that the stark hierarchies present in the rest of society also permeate the social field of medicine. In many parts of the world, help-seekers are sensitive to perceived prejudices and hyper-aware of unequal access to resources such as treatments, and this shapes their health-seeking strategies. Crandon-Malamud (1991) describes how villagers in a Bolivian community in the late 1970s used the choices they made about therapeutic help-seeking not only to try to resolve health problems but also to establish desired ethno-religious identities in the eyes of their neighbours, forge alliances and access resources not directly related to their medical care. By going to the Methodist-funded clinic, one might be making a statement about one's modernising aspirations or religious loyalties from which social alliances or access to education might flow; by consulting traditional shamanic healers, one might be staking a claim to the support of other neighbouring families and pursuing moral standing within a different collectivity. Strategies might be employed somewhat differently in a context where there is less scope to pass from one grouping to another. Gold and Clapp's (2011) study of a rural Quechua village in highland Peru reports how residents extol the virtues of the herbal knowledge in their village, at least partly as a response to knowing that they are discriminated against and excluded from access to high-quality biomedical services, and that there is little they can do to change this. Here the value placed on traditional healing is, in the view of the authors, the product of necessity, even if it may at first seem a source of pride and the exercise of free choice.

Elsewhere, choices about resort to different healers may reflect management of the moral politics within one's family or community; diagnosis, particularly in mental health, can carry a freight of moral implications. Brodwin (1996), for example, describes how in Haiti, patients and families tended to prefer a psychiatric diagnosis over those from traditional healing, as this avoided suspicions of having incurred sorcery. In contrast, Callan (2012) found the opposite to be true in Bangladesh, with intimations of sorcery having the advantage over biomedical diagnoses that they allowed families to legitimate their grievances against the person(s) suspected of sending the illness and relieved them of personal responsibility for their misfortunes. Whether diagnosis occurs within one paradigm or another thus often has significant social effects. However, these do not always occur in simple or predictable ways, and may vary depending on the social position of the family concerned (ibid., p. 199) and the extent to which they are able to direct or influence the discourses around their situation.

The social situation of those experiencing mental health issues and their families, and their responses to it, thus interact with the social status of a religion, tradition or medical institution to produce particular configurations of medical pluralism specific to each setting. Combined with prevalent local understandings of what madness or distress is, these configurations powerfully determine the stigma experienced by people with mental disorder (see White, Padmavati, and Kumar this volume). In GMH, it is commonly argued that the stigma attached to consultation with psychiatric services is one of the reasons why alternative healers continue to prove so popular (Burns and Tomita 2014). While this may not be true everywhere, it is often a consideration for help-seekers, and since—like primary care services—traditional healers are generally consulted for a wider range of issues, being seen to attend one does not automatically signal to observers that they are dealing with mental health problems.

In bringing this subsection to a close, it is important to note that current developments, of which the movement for GMH itself is an important one, are having significant impact on the field of power relations in which mental disorder sits. State intervention and regulation is one of the key factors in delimiting which forms of healing are permitted or seen as desirable. The *WHO Traditional Medicine Strategy 2014–2023* encourages member states to afford a level of legitimacy to certain forms of traditional healing, though within a developing framework of regulation and the promotion of ‘rational use’ (WHO 2013, p. 11). This provides both openings for, and restrictions on, traditional healing practice, with research institutes and licensing systems in some countries creating new imprimaturs of official ‘authenticity’ for healers (Langwick 2011). With the growing influence of globalised media and human rights activism, scandals of mental health care now prompt government intervention in a way that was previously rare in LMICs (Quack 2012; Patel et al. 2012). The GMH movement and allied organisations have been instrumental in raising the profile of human rights for the mentally ill and pressing governments to update or create legislation to address failings in this area (see Stavert this volume). Some of these measures—to the extent that they are actually implemented—affect other forms of healing, either directly or indirectly. Traditional healing has shown its adaptability in the past; the current confluence of challenges and opportunities presented by GMH will no doubt elicit equally interesting responses in the future.

Conclusion

There is a long history of debates around the alliances that biomedicine and psychiatry might make with traditional healers. At times these have borne fruit; other attempted projects have been discarded as unsuccessful. The emergence and rapid growth of GMH is adding a new chapter to this story. Part of the moral force of the Movement for GMH stems from the contrast it draws between its own empowering, rights-based approach—advocating for scientific treatments, legal protections and participation in society—and older, more restrictive, abusive or neglectful practices. The latter have often been identified in mental hospitals, but traditional healing has also come in for criticism (Kleinman 2009, p. 603; Patel et al. 2012). At the same time, the Movement's leaders are, in many respects, pragmatists, quite willing to collaborate with traditional healers if doing so leads to better outcomes. Staunch advocates of such collaboration in GMH are forcefully putting the case that this should happen (e.g., Incayawar et al. 2009), and there are projects underway exploring the possibilities (e.g., PAM-D 2013). Others caution that putting it into practice will not be simple and indeed may be detrimental to the healing outcomes it seeks to improve (Quack 2012; Sax 2014). Whichever course is adopted—antagonism, integration or the maintenance of a respectful distance—it should be informed by careful consideration of the issues that we have been able to touch on only briefly here. To ignore medical pluralism would be to ignore the reality for many of those that GMH seeks to help, an option that few involved in advancing GMH will find palatable.

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16

Mental Health Law in a Global Context

Jill Stavert

In recent years, the focus of international human rights realisation has moved from the making of international human rights law to its implementation and enforcement at the national level (Murray and Mottershaw 2012). This reflects a growing appreciation that human rights remain aspirational only if they are not given real effect within states. This chapter will therefore consider international and regional human rights standards identified in treaties that apply to persons with mental health issues and their reflection at national level. In particular, it will identify challenges to such implementation. Some specific country examples will be provided but, as many of the issues are common to all or many jurisdictions, a general overview will predominantly be given.

Human Rights Implementation: The Importance of National Legislation and Policy

The World Health Organization's (WHO) *Mental Health Action Plan 2013–2020 (MHAP)*, in reaffirming good mental health as an integral element of health and wellbeing, identifies as one of its four objectives the strengthening of effective leadership and governance for mental health and as one of six 'cross-cutting principles and approaches' that:

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> Mental health strategies, actions and interventions for treatment, prevention and promotion must be compliant with the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments. (WHO 2013, p. 10)

Moreover:

> Mental health law, whether an independent legislative document or integrated into other health and capacity-related laws, should codify the key principles, values and objectives of policy for mental health, for example by establishing legal and oversight mechanisms to promote human rights and the development of accessible health and social services in the community. (WHO 2013, p. 12, para 32)

The MHAP notes that only 36% of people living in low-income countries, as opposed to 92% of those living in high-income countries, are covered by mental health legislation. It accordingly sets global targets that, amongst other things, by 2020, 80% of countries will have developed or updated their policies or plans for mental health and 50% of countries will have developed or updated their mental health laws in line with international and regional human rights instruments (WHO 2013).

These WHO objectives and targets very much reflect the generally held view that the real and effective implementation of international human rights standards that apply to persons with mental health issues reduces the risk of abuse in care and treatment situations, as well as stigma and marginalisation. It also drives forward equality of access to care and treatment and to support and services that are vital for rehabilitation and recovery, for the maintenance of good mental health and for underpinning professional ethical standards. It further reinforces what it identified in its 2005 *Resource Book on Mental Health, Human Rights and Legislation* which is that for rights to genuinely benefit those the people are meant to protect they must find expression in policy and, most importantly, legislation accompanied by robust enforcement mechanisms (WHO 2005).

Human Rights and Mental Health

All international and regional human rights instruments direct that there must be universal and non-discriminatory respect for human rights. The presence of psychiatric illness or other mental disorder should not of itself, therefore, justify the denial of any human rights.

Certain human rights are of particular relevance in the context of the care and treatment of persons with mental health issues.[1] These include civil rights relating to the exercise of individual autonomy, detention, freedom from torture, inhuman or degrading treatment, the right to life, the right to a fair hearing and the ability to challenge or request an independent court or tribunal to review their detention or treatment and for appropriate remedy to be made. However, other rights are also of importance to the recovery and maintenance of good mental health, such as the right to contact with family and friends, respect for one's culture and religion, and access to support and services (including welfare benefits, adequate housing, mental and physical healthcare and employment opportunities). Unfortunately, these latter rights fall within the socio-economic rights category, and, as will be discussed later, implementation of such rights has traditionally lagged behind that of civil rights, which themselves have an uneven implementation track record.

International and Regional Human Rights Law: The Emerging Prominence of the United Nations Convention on the Rights of Persons with Disabilities

The above-mentioned rights and/or outcomes are identified in many international human rights treaties, such as those adopted under the auspices of the United Nations (UN). These include the International Covenant on Civil and Political Rights (UNICCPR), International Covenant on Economic, Social and Cultural Rights (UNICESCR), Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT), Convention on the Elimination of All Forms of Discrimination Against Women (UNCEDAW) and Convention on the Rights of the Child (UNCRC). Additionally, the UN's Universal Declaration of Human Rights (UDHR) and UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1991) ('MI Principle') have for

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[1] This chapter considers legislation that authorises the care and/or treatment of persons with mental illness, and, for this reason, the term 'mental health issues' is used to denote mental illness. However, it is acknowledged that the term 'mental health' is not confined to mental ill-health and includes mental wellbeing. See, for example, Article 12(1) UN International Covenant on Economic, Social and Cultural Rights that defines the rights to health as 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'. See also the WHO definition of mental health: 'Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community'. WHO, *Promoting mental health: concepts, emerging evidence, practice*, 2004.

some time set out non-legally binding, but highly influential, principles that should be adhered to in the context of care and treatment of persons with mental health issues.

At regional level, we find the African Charter on Human and Peoples' Rights (Banjul Charter), American Convention on Human Rights, Additional Protocol to the American Convention on Human Rights in the area of Economic, Social and Cultural Rights, Inter-American Convention on all Forms of Discrimination Against Persons with Disabilities, Inter-American Convention to Prevent and Punish Torture, European Convention for the Protection of Human Rights (ECHR) and Fundamental Freedoms, European Social Charter and European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. The Council of Europe has also adopted two important non-legally binding but influential recommendations in the form of Recommendation R(99)4 *Principles Concerning the Legal Protection of Incapable Adults* and Recommendation Rec (2004)10 *concerning the protection of the human rights and dignity of persons with mental disorder.*

Globally, it is, however, the UN Convention on the Rights of Persons with Disabilities (CRPD) that arguably nowadays takes the lead in terms of the rights of persons with mental health issues. Heralded as a revolutionary treaty its approach is very different to that of previous human rights treaties, which have tended to recognise the rights of persons with mental health issues primarily in terms of justifying those circumstances when the denial of their rights is permitted. It also provides a very pertinent illustration of the dynamic nature of human rights discourse, which the international community, and individual states, must constantly strive to accommodate.

The Ad Hoc Committee, established by the UN General Assembly to consider proposals for what became the CRPD, took the unprecedented step of also inviting suggestions from non-governmental organisations (UN Resolution 56/51) and from persons with disabilities and their representatives (UN Decision 56/474). Indeed, this involvement of civil society in the CRPD drafting negotiations has led some commentators to observe that the treaty was largely written by disabled persons (Lawson 2007; Kämpf 2008). The CRPD has often been referred to as representing a 'paradigm shift' in that it seeks to protect and promote persons with disabilities[2] by way of a social model of disability rather than the more paternalistic traditional medical model. Moreover, it adopts the stance that it is societal attitudes to disabilities that are disabling and not the disability itself. It thus closely aligns non-discrimination with human rights and requires state parties to actively ensure that state authorities,

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[2] Defined as 'long-term physical, mental, intellectual and sensory impairments' (Article 1).

private bodies and individuals promote the effective living and participation of persons with disability in society. Indeed, as will be mentioned later, it has been argued that the CRPD usefully seeks to ground human rights of the persons with disabilities within a theory of social justice (Venkatapuram 2014).

However, whilst the existence of apparently commonly held values has considerable advantages, implementing the rights identified in international and regional human rights instruments through law and policy at national level is not without its challenges.

The Reality of Human Rights Implementation and Compliance

Legislation in some countries does strive to reflect and give real effect to such rights. Scotland's Mental Health (Care and Treatment) (Scotland) Act 2003 has, for instance, been widely regarded as an example of legislative good practice in terms of its promotion of patient-centred and human rights-based care and treatment (Ridley et al. 2009; Fischer 2006).[3] Ghana's Mental Health Act 2012 has also been lauded by the WHO as an example of best practice in this field (WHO 2007). Moreover, South Africa's Mental Health Care Act (No 17 of 2002) involved stakeholders (namely user groups, service providers, professional organisations and non-governmental organisations in its drafting) (WHO 2007) and seeks to safeguard the rights of persons with mental health issues through various legal requirements that drive procedures and management of care and treatment. It has been regarded as a significant improvement on the mental health legislation of the apartheid era (Lund et al. 2012).

In many other jurisdictions, however, mental health legislation is woefully outdated and does not reflect current international human rights standards, or is even non-existent (WHO 2013). This is common in, but certainly not entirely confined to, low- and middle-income countries (LMICs) (Hanlon et al. 2010; Patel et al. 2012). Lund et al. (2012) mention, for example, Uganda and Zambia, which still retain mental health legislation enacted 50 or more years ago.

In some jurisdictions, patients are subjected to involuntary treatment (including unmodified electroconvulsive therapy[4]) without justification, informed consent or the ability to appeal such decisions to an independent

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[3] It is also hoped that the Mental Health (Scotland) Bill 2014 currently being considered by the Scottish Parliament and which seeks to amend aspects of the 2003 Act will not be regressive in this respect.

[4] See James et al. 2009.

court or tribunal or, indeed, appeal to any person or body (Patel et al. 2012). Institutionalised patients are kept in decrepit and filthy buildings and conditions, their dignity is not respected, they are subjected to long periods of seclusion, are placed in cage beds, and restraint and seclusion are routinely used as tools of punishment or for convenience rather than legitimately and proportionately. There may also be a lack of stimulation, social isolation, children and adults being accommodated together and patients being subjected to violence and rape by staff and other patients (Patel et al. 2012). Nor do persons with mental health issues necessarily fare any better, or experience greater respect for their rights, if they remain at home and in the community (Patel et al. 2012).

It is therefore worth considering those factors that contribute towards the human rights of those with mental health issues not being given full and meaningful expression within states. The following will highlight some of these.

Challenges to Effective National Implementation of Human Rights Standards for Persons with Mental Health Issues

National Constitutional Arrangements and International Law Obligations

Treaties create a binding obligation upon state parties under international law. However, whilst all human rights treaties do require state parties to ensure domestic implementation of their obligations, the extent to which treaty standards find expression and create nationally enforceable rights depends on a particular state's constitutional approach to international law. The reality is slightly more nuanced but, broadly speaking, states adopting a 'monist' approach tend not to regard international and national law as two distinct systems. Rights identified in international or regional human rights treaties ratified by their governments will therefore be automatically incorporated into, and take effect, within their domestic laws.

On the other hand, those states adopting a 'dualist' approach seek to protect their national sovereignty by regarding the two systems as separate and require the enactment of specific domestic legislation to give expression to the rights at national level. The United Kingdom for instance adopts a dualist approach to international and regional treaties, and for the ECHR to be incorporated into the UK legal framework, the enactment of the Human

Rights Act 1998 was thus required. The Human Rights Act gives effect to such rights within the United Kingdom by requiring public authorities (e.g., government departments, local authorities, the police, courts and hospitals) to act in a way that protects and respects the ECHR of individuals,[5] for legislation to be interpreted insofar as it is possible with such rights[6] and for the courts and tribunals to interpret questions concerning such rights in accordance with the jurisprudence of the ECHR.[7] The rights identified in other international treaties that have been ratified by the United Kingdom, such as the CRPD, ICCPR and ICESCR, are not given effect nationally in the same way. This means that wherever a conflict between the rights in these treaties and ECHR then, currently, ECHR will prevail.

Whichever constitutional approach to international law is adopted, national courts may be influenced by the state's international obligation to respect such rights but there is no guarantee that they will enforce them unless they are given effect nationally. Where such effect is not provided nationally then a state party's obligations remain those under international law only. In these situations, rights identified in treaties are enforceable only through the relevant treaty's implementation mechanisms such as periodic reporting, interstate complaints and, where a state expressly consents, individual complaints or communications. These methods are, however, relatively more cumbersome and less effective than national remedies (such as applications to national courts or tribunals) for rights violations.

Another significant factor relating to international treaty implementation is that many treaties, including the CRPD, require ratification after signature by a state in order to become legally binding on that state. This reflects the fact that signature of a treaty is an act of the state's executive, which will often require the subsequent approval by, or at very least debate in, its legislature before it becomes so binding. Whilst it appears to be generally accepted that an obligation of good faith exists that after signature and prior to ratification that the state will not frustrate the object of the treaty (International Law Commission 1966), clearly a significant delay in or failure to eventually ratify a treaty implies a lack of national commitment, by the executive or the legislature, to such treaty objectives. It is therefore worth noting that, at the time

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[5] Section 6.

[6] Section 3.

[7] Section 2(1). It should be noted, however, that courts and tribunals are not permitted to declare legislation provisions that are incompatible with ECHR rights invalid. They can simply make a declaration of incompatibility (section 4). It is then in the UK Parliament's discretion whether it takes the necessary measures to remedy such incompatibility. In the meantime, the national legislation stands despite being incompatible.

of writing, around 30 of the 159 signatories to the CRPD have yet to ratify it. In addition, 85 of the 92 signatories to the Protocol to the CRPD (recognising the right of individuals, groups and third parties to submit complaints to the CRPD's oversight body, the Committee on the Rights of Persons with Disabilities) so far have failed to ratify it. However, in both respects, it is informative that LMICs are roughly equally represented amongst those showing lack of, or delay in, ratification.

The Rule of Law and Human Rights

There is a strong correlation between a state's adherence to the rule of law and the extent to which rights are respected and protected (United Nations 1993; Ochoa 2015). It goes to the very foundation of successful implementation of laws that are founded on international human rights standards. The conceptualisation of the rule of law may differ between states and people, but it is generally accepted that, as a minimum, it should crucially encompass factors such as the state (e.g., the police and mental health professionals employed by the state) not acting arbitrarily and consistently applying human rights-based law. Moreover, it is essential that there is an independent and incorruptible judiciary where the appointment, tenure and operation of judges are free from executive interference, and individual members of the judiciary do not adjudicate in proceedings in which they may have a personal interest in the outcome. Certainly, evidence seems to suggest that countries lacking effective legal frameworks, regulatory and oversight bodies[8] (in terms of quality of care and treatment and professional ethical standards) are less likely to respect the rights of persons with mental health issues in treatment settings (Hanlon et al. 2010). In such situations, such persons are more likely to be subjected to involuntary treatment without justification with limited or no ability to judicially challenge this and where those responsible will be held to account (Bartlett 2010).

A lack of strong commitment to the rule of law can even be discerned in some countries, such as some of those in Central Europe, in terms of the nature, rather than a lack, of care and treatment (Bartlett 2010). In such countries, issues that can arise include poor institutional conditions, the use of caged or net beds, routine use of guardianship to entirely strip individuals of their right to exercise legal capacity and an absence of community-based care (Bartlett 2010; European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment 2015). Legal procedures

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[8] For example, national human rights institutions or commissions or boards with equality and human rights mandates.

may exist in such countries, but they do not operate within the perimeters of a human rights framework where there is little available legal representation and even when it does exist the lawyers are reluctant to challenge procedures which may, for example, permit involuntary detention and treatment (Bartlett 2010).

Responsibility for Implementation of Rights

Whilst international human rights treaties confer rights on us as individual human beings, it is states who are parties to such treaties and, as such, are the only entities that can be held directly responsible for poor implementation and rights violations. Yet, private bodies and individuals may be involved in the care, support and treatment of persons with mental health issues. In such cases, individuals with mental health issues would only be able to ensure that their rights are respected and protected, and any redress obtained, where the state's regulatory and legal framework creates such a responsibility, that is to say the state places a duty on the individual or private entity to act in a manner that is commensurate with human rights and the state is then obliged to enforce such duty. Indeed, international and regional human rights treaties require state parties to do this. For example, Article 2(2) ICCPR, Article 1 of the Banjul Charter and Article 1 ECHR all place a positive obligation on state parties to protect individuals against interferences with their rights and direct that they must give effect, by legislative or other means, to the rights identified in them.

How effectively this operates in practice depends, however, on the rigour with which a state fulfils its obligations in this respect. Additionally, where a state authority colludes in the abuse of human rights, the state will be held responsible. For instance, the ECHR ruled in *Storck v Germany*[9] that the state had violated the applicant's right to liberty[10] owing to the fact that state police returned her to a private institution where she had been unlawfully detained. Likewise, Article 8 of the International Law Commission (2001) *Articles on Responsibility of States for Internationally Wrongful Acts* provides that an act of a person or group of persons will be regarded as the act of the state where such a person or group of persons is acting on the instructions of, or under the direction or control of, that state.[11]

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[9] (61603/00) (2005) ECHR 406, para 89.

[10] Article 5 ECHR.

[11] Although international courts and tribunals have differed as to how widely 'direction or control' should be interpreted (see, e.g., *Nicaragua v United States of America (Merits)*, Judgement of 27 June 1986, ICJ Reports 1986, 14 and *Prosecutor v Tadic*, Case No. IT-94-1-A, Judgement of 15 July 1999).

The Nature of Rights Themselves

As alluded to earlier, the very nature of the different categories of human rights may also militate against their effective implementation. Rights to liberty, life, freedom from inhuman or degrading treatment, autonomy and the exercise of legal capacity and due process, commonly associated with the involuntary care and treatment of persons with mental illness, are civil rights and tend to be ‘negative’ in nature, in that they require states only to refrain from acting in particular ways. Socio-economic rights, on the other hand, such as the right to the highest attainable standard of physical and mental health, education, housing and benefits require positive action on the part of states and, usually, the allocation of public resources, which presents a challenge politically and economically for all countries. For this reason, many states have traditionally been more reluctant to reinforce socio-economic rights through national legislative and policy frameworks.

Whilst progress has been made, particularly in Europe, in terms of recognition of civil rights in institutional care settings, much less emphasis has generally been paid to socio-economic rights. Yet the ability to enforce socio-economic rights nationally is essential in order to ensure access to the necessary support and services which are fundamental to a person’s effective functioning in community settings (Stavert 2007). That this problem is not simply confined to LMICs can be illustrated by the UN Committee on Economic, Social and Cultural Rights (2009) criticism of the United Kingdom for regarding ICESCR rights as being mere values and not incorporating them into domestic laws (and thereby making them legally enforceable).

However, despite statements affirming the equal status of civil, political, social, economic and cultural rights at the 1993 Vienna UN World Conference on Human Rights, fewer states have, for example, ratified the ICESCR than the ICCPR. Moreover, socio-economic rights are rarely referred to specifically in states’ constitutional documents. This is exacerbated by the fact that international treaties promoting social and economic rights are generally pragmatic and permit the progressive realisation of such rights. For this reason, national, international and regional courts and tribunals, responsible for adjudicating human rights issues, tend to be reluctant to specifically direct state authorities as to how they should apply resources. That being said, the UN Committee on Economic, Social and Cultural Rights (2000) has made it clear that repeated attempts to justify non-, or delayed, implementation of the right to the highest attainable standard of physical and mental health, on the basis that progressive realisation is tolerated, are unacceptable.

Further tensions also exist as to what rights actually ought to achieve. According to Venkatapuram (2011), this meaning may be lost somewhere between what are understood as the objectives of international human rights standards and what these rights are actually supposed to be achieving in real terms for the lives of the humans they seek to protect. This may be due to different interpretations as to what a particular right actually means—he notes, for instance, the dispute as to whether a right to health actually exists or, instead, a right to healthcare—and differing theories of social justice adopted at international and national level. In an attempt to resolve this, he therefore suggests (Venkatapuram 2011) the adoption of Sen's *Capabilities Approach* theory of social justice (Sen 2005), in which health rights must be justified and grounded essentially in terms of entitlements in order to achieve those things that make for a healthy life, such as staying alive and functioning physically and mentally,[12] and that the CRPD offers a good vehicle by which to attain this (Venkatapuram 2014).[13] For persons with mental health issues this would mean, amongst other things, protection from abuse and discrimination in care and treatment and adequate provision of the support and services required to enable as full and effective recovery and rehabilitation as possible.

Ideological Differences: Universalism versus Relativism

Differing ideological approaches to human rights can impact on the extent to which states ratify international human rights treaties. It also influences whether national legislation reflects these international norms and is implemented in a manner that is faithful to the aims and objectives of the treaty (Alston and Goodman 2013).

The rights identified in international human rights treaties are not always, however, regarded as representing indisputable universally accepted norms and the aforementioned 1993 UN Vienna Conference and resultant Declaration endeavoured, arguably not altogether successfully, to address the universalist and relativist dichotomy.

The universalist approach has been challenged on the basis that international human rights standards are entirely constructs of Western developed liberal democracies which do not take into account different cultural,

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[12] See also Daniels (2008).

[13] See also Nussbaum (2003) on the capabilities approach as a theory of social justice, albeit in relation to gender issues, and Harnacke's critique (2013) of whether the capabilities approach, as advocated by Nussbaum, can, however, be usefully applied in the context of the CRPD.

religious, historical, economic and political ideologies or realities (Kastrup 2010; Mutua 1996, 2004).[14] Such critics argue that the universalist approach places undue emphasis on highly individualistic, predominantly civil and political, rights, which have no place in societies where adequate housing and living conditions, education and health (and by consequence the underpinning socio-economic rights) are of much greater significance or where duty to family or society is paramount and overrides individualism (Alston and Goodman 2013; Roth 2004; An-Na'im 1995).

In particular, individual autonomy may not have the same meaning or have less value placed on it in certain societies. Indeed, in LMICs there is often greater emphasis placed on community and responsibilities than on individual autonomy (Hanlon et al. 2010). Kastrup (2010) comments that interpretations of the concept of autonomy, which very much underpin the approach to mental health care and treatment in the West, may differ between individualistic and collectivistic cultures. She argues that insisting on Western interpretations of autonomy and the related concept of informed consent may actually have negative consequences for the doctor-patient relationship in other cultures. Moreover, in Western societies, the notion of autonomy has invariably been seen as pertaining to an individual person. In other societies, this may be broadened to include the family unit. Alem et al. (2002), for instance, reporting on a study of compulsory psychiatric treatment in Ethiopia, note that family and individual family members are seen as indistinguishable and therefore suggest that whilst clinical decisions to admit for involuntary treatment did not seem to have been influenced by specific requests made by family members, an individual would not be seen as presenting for treatment without this being supported by their family. They also suggest that the same perception exists when medical staff are prepared to provide family members with patient information against the patient's wishes. Additionally, the preservation or the restoration of health may take precedence to individual patient choice in LMICs (Hanlon et al. 2010).

It is arguable that regional human rights protections systems may offer, on a practical level, stronger enforcement mechanisms, which are less likely to be viewed with suspicion than their international counterparts. However, despite the fact that the content of regional treaties may on the face of it be more aligned to regional cultural values—the Banjul Charter, for example, gives particular emphasis to duties as well as rights,[15] thus illustrating its regional

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[14] For contrasting views, see Osiatynski (2004) and Subramanya (2008).

[15] Such duties include those towards one's family, society and national and the international community to pay taxes, preserve and strengthen positive African cultural values and to contribute towards the promotion and achievement of African unity. See Articles 27–29, Banjul Charter.

distinctiveness (Alston and Goodman 2013)—it has been noted that such treaties in fact say very little that is fundamentally different to international human rights treaties (De Schutter 2014; Mutua 1995).

The fact remains, however, that the exploitation of, and discrimination against, persons with mental health issues in terms of their care and treatment is a universal issue and thus requires a global approach. Moreover, in countries that have been more amenable to international human rights standards, there is clear evidence that such abuses have been more effectively addressed. It is therefore arguable that, together with meaningful dialogue on cultural difference, these international standards can indeed be applied nationally in a culturally appropriate manner without losing their protective and empowering essence (Kirmayer 2012).

It should be noted that even the most enlightened may occasionally struggle with the directions of international bodies charged with implementing international human rights law. A notable current example is the interpretation of the right to equal recognition before the law by the UN Committee on the CRPD in its General Comment on Article 12 CRPD (2014). This interpretation essentially provides that to deny the exercise of legal capacity (in other words, to exercise and have respected autonomous decision-making) on the basis of mental incapacity is discrimination and that no one must be subjected to involuntary measures without their specific consent. Individuals may therefore be supported to make decisions about their lives, including those concerning care and treatment for mental disorder, but such decision-making must not be substituted by others. To this end, the General Comment therefore radically directs that CRPD state parties must abolish guardianship and laws permitting involuntary treatment for mental disorder. The recognition of a person's legal capacity has far-reaching implications for the exercise of most, if not all, rights. Indeed, it is clear that individuals and public and private bodies across the globe are struggling, often with the best of motivations, as to the viability and practicalities of implementing such a directive.[16] This struggle is demonstrated not least in terms of reconciling the conflict that exists between General Comment and interpretations of the right to exercise legal capacity under other international and regional human rights treaties themselves.[17]

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[16] For an indication of the differing views regarding this General Comment, which was adopted in almost an identical form to that consulted upon, see the consultation responses http://www.ohchr.org/EN/HRBodies/CRPD/Pages/DGCArticles12And9.aspx

[17] For example, Article 8(2) ECHR permits the limitation of the right to private and family life in certain specified circumstances where it is lawful and proportionate to do so. This too is reflected in the Banjul Charter (see Articles 3 and 27–29). In addition, the UNHRC (2014), responsible for overseeing the implementation of the ICCPR, has adopted a different interpretation to that of the UN Committee on the CRPD.

Societal Attitudes

Socio-cultural values of legislators, policy-makers, persons with mental health issues, their families and practitioners may also impact on the effectiveness of national implementation of international and regional human rights law (Patel et al. 2012). Stigmatisation, marginalisation and prejudice are commonplace, including in the language used in connection with persons suffering from mental health issues (Callard et al. 2012). Not only is this directed towards persons with mental health issues but also towards their families, carers and even mental health professionals (Becker and Kleinman 2013). The impact of such stigma may also cause health policy experts to place less emphasis on mental health care (Becker and Kleinman 2013).[18] Additionally, some groups of people with mental health issues may be more susceptible to discrimination than others. In Europe, for example, discrimination against ethnic minorities has been evidenced in terms of accessing and using mental health services (Kastrup 2010; Sashidharan 2001).

The enhanced role of the family in LMICs may militate against the realisation of individual rights. In these countries it is often generally accepted that families assume decision-making powers for individuals with mental health issues. In such situations, clinicians may therefore be more influenced by what they perceive to be the wishes of the family rather than those of the patient (Hanlon et al. 2010) and, as previously observed, may not conceptually make a distinction between the wishes and preference of family as a whole and those of the individual with mental health issues. An individual's cultural beliefs concerning mental illness may also affect treatment assessment and decisions and potentially deny them the legal and human rights protection they require. For instance, if a patient believes that their condition is the result of demonic possession it may be very difficult for a psychiatrist to ascertain just how much this perception can be attributed to the condition itself or to how the patient personally perceives the symptoms of their illness (Bartlett 2010; Ayon-Rinde et al. 2004).

Nationally and globally mental health professionals may also collude to maintain the status quo rather than move forward, thus perpetuating a high level of institutionalisation of persons with mental health issues and under-resourcing of care, support and treatment services that are most relevant to them (Patel et al. 2012). Whilst no dedicated research appears to have been

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[18] Becker and Kleinman (2013) note that there are, however, indications that the Ministry of Health in China and similar agencies in other countries are starting to promote the interests of persons with mental health issues.

conducted in relation to this, it is certainly arguable that factors such as the aforementioned cultural and societal attitudes towards mental health issues and human rights, political regimes, a lack of awareness and personal and professional self-interest may be motivating factors.

Lack of Information, Awareness or Knowledge

A lack of awareness by patients and their families about rights may also hinder their implementation and enforcement. The South African Mental Health Review Boards are mandated under the aforementioned 2002 legislation to act independently and autonomously as quasi-judicial bodies to uphold the rights of persons with mental illness and learning disabilities and have certainly helped rights recognition (Lund et al. 2010). However, as Lund et al. (2010) note, they nevertheless face challenges in terms of communicating their role and functions to the public, especially in rural areas, and, despite the weight the Boards' recommendations carry, the Executive is still able to override their decisions. These issues are not unique to LMICs, despite the Mental Health (Care and Treatment) (Scotland) Act 2003 being, as previously mentioned, largely regarded as human rights based; recent research conducted on behalf of the Mental Welfare Commission for Scotland found that few individuals with mental health issues know what their rights are (Griesbach and Gordon 2013).

Nor should it be forgotten that although there is increasing support for the involvement of experts by experiences (i.e., people with a lived experience of mental health issues and/or their families) in mental health policy development and implementation, which clearly impacts on the quality of mental health law and the extent to which these respect experts by experience rights (WHO 2013; Bartlett 2010), the ability to participate may be limited. A lack of state receptiveness to such user involvement may be a contributory factor here, but persons with mental health issues may be hindered by the lack of availability of early and effective access to treatment and support, wider supportive networks and the necessary training or experience to help achieve such participation (Kleintjes et al. 2010).

Reduced professional knowledge of human rights requirements also exists. As Hanlon et al. (2010) note in relation to India, Ethiopia and South Africa, there is a lack of awareness on the part of clinicians of ethical standards, informed by human rights standards, or of how to make proper assessments of the justification for involuntary treatment and accurate diagnoses of mental disorder.

Resourcing Issues

The under-resourcing of appropriate, good-quality and evidence-based mental health care often results in persons with mental health issues not receiving the type of care and treatment they require or that which is appropriate for them (Hanlon et al. 2010). This inevitably affects the emphasis given to their rights even where appropriate legislation is present. For instance, it would appear that for most LMICs, the importance placed on the right to autonomy is often outweighed by the need to actually access mental health care when required (Hanlon et al. 2010). Lund et al. (2012) make similar comments regarding Ghana, South Africa, Uganda and Zambia. Moreover, Alem et al. (2002) suggest that the considerable use of restraint in Ethiopia in nearly all cases where behaviour is disruptive, and the high use of ECT as opposed to appropriate medication, may be attributable to the lack of adequate resourcing. On the other hand, again in relation to Ethiopia, Alem et al. (2002) also note that owing to the scarcity of mental health services, involuntary admissions are more likely to be appropriately made.

The lack of available and appropriate mental health care can also leave responsibility of care for persons with mental health issues to their families or alternative forms of care. In these situations, their human rights may be violated but in the absence of a protective legislative framework that might exist if they were subject to the care of the state. Families may, for example, through lack of alternatives chain them up or administer medication covertly (Hanlon et al. 2010; Patel and Block 2009). The UN Rapporteur on Torture, Juan E. Mendez (2014), has also reported that whilst human rights abuses also occur in psychiatric hospitals in Ghana,[19] many people with mental illness are placed in privately owned and widely used prayer camps that routinely shackle and deny food and clinically approved medication as part of a process of spiritual healing.

Conclusion

As indicated at the outset of this chapter, for international human rights standards to truly protect persons with mental health issues, we need to concentrate on the implementation and enforcement of such rights at national level. To date, however, as Bartlett (2010) writes, most literature providing a critique of mental health laws has tended to be influenced by the jurisdictions

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[19] For example, inhuman and degrading treatment in the form of poor sanitation and overcrowded conditions, lack of food and appropriate medication and the administration of ECT without anaesthesia and not as a last resort.

of economically advanced countries (namely New Zealand, North America, Western Europe and Australia) where individual rights are, and have for some time been, part of the legal culture.

It is possibly all too easy to acknowledge the barriers that limit reflection of international human rights standards in national legislation and policy and its ability therefore to bring about the social change necessary to improve the care and treatment of those with mental health issues. Nor should we rule out the fact that a tendency to focus on mental health laws has inculcated the idea of persons with mental health issues as 'patients' with limited rights rather than as citizens entitled to rights in all aspects of their lives (Callard et al. 2012). Such focus also means that we may be blinkered in our approach to human rights and not identify violations which occur outside the application of the law, for instance, in the case of informal patients who may be coerced into various forms of psychiatric treatment (Bartlett 2010) or who, owing to societal attitudes or a lack of suitable mental health facilities and support, may fall outside the reach of human rights-based legislative protection (Hanlon et al. 2010; Patel and Block 2009; Mendez 2014).

It is nevertheless impossible not to emphasise the powerful role that such legislation and policy play in supporting the implementation of international human rights standards or the vital role of enforceable rights to protect persons with mental health issues in care and treatment situations (Bartlett 2010). Moreover, the importance of international treaties such as the CRPD must not be underestimated in driving forward such change, particularly its promotion of the social model of disability. In this respect, it may therefore be worth further exploring the merit and usefulness of the suggestion that it promotes the capabilities approach theory of justice (Venkatapuram 2014). Nor should it be forgotten that, irrespective of national legislation and policy reflection of international human rights norms, state parties nevertheless have a binding obligation in international law to ensure their recognition and protection nationally. At the same time, however, whilst remaining true to these international standards, it is important to have cognisance of the different political, economic, cultural and legal contexts in which such legislation and policy operates in order for it to be most effectively implemented (Kirmayer 2012).

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17

Suicide in Low- and Middle-Income Countries

Baffour Boaten Boahen-Boaten, Ross G. White, and Rory.C. O'Connor

Although a global issue, suicide has historically been regarded as a concern of the developed high-income countries (HICs) and has been considerably neglected in the low- and middle-income countries (LMICs) (Gvion and Apter 2012). One major reason given for the little attention paid to suicide in LMICs has been the prioritisation of the comparatively more prevalent infectious, maternal and infant mortality health problems (Vijayakumar 2004). Additionally, in some LMICs suicide constitutes a taboo subject evoking tremendous religious, sociocultural and legal sanctions, and this militates against its recognition as a subject of concern (Adinkrah 2012; Gureje et al. 2007). Despite these factors, suicide in LMICs is increasingly garnering attention in recent years (Hawton and van Heeringen 2009). This is exemplified by the recognition of suicide by the World Health Organization (WHO) as one of the priority areas in the mental health Gap Action Programme (mhGAP) which focuses particularly on LMICs (WHO 2008) and the recent WHO landmark publication, titled 'Preventing Suicide: a global imperative' (WHO 2014).

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In line with the current global attention on suicide in LMICs, this chapter explores risk factors for suicide in LMICs.[1]

Global Mental Health Perspectives on Suicide

The perspectives of *burden* and *need for equity* underpinning Global Mental Health (GMH) (Patel 2014) establish the imperative and legitimacy for suicide in LMICs to be prioritised.

Burden

Burden is defined as the sum total of the consequence of a condition (WHO 2004). The Disability Adjusted Life Year (DALY) is the metric that is used by the WHO to measure the burden caused by 235 different health conditions. The DALY combines the number of years of life lived at less than full health with the number of years of life lost premature, providing a combined measure of mortality and disability. Figures from the Global Burden of Disease 2010 study indicate a total of 36.2 million (26.5–44.3 million) DALYs attributed to suicide in 2010, with estimates suggesting that mental and substance use disorders were responsible for 22.5 million (14.8–29.8 million) of these DALYs, that is, 62% of the burden caused by suicide (Ferrari et al. 2014). Importantly, data on suicide particularly from LMICs lack reliability owing to significant differences in registration between countries and values and social pressures which affect people's reporting behaviour (Adinkrah 2012; Hawton and van Heeringen 2009). Thus one could speculate that suicide mortality and morbidity in LMICs may actually be higher than documented.

LMICs bear a substantially larger share of the mortality burden associated with suicide than HICs (Bertolote and Fleischmann 2002; WHO 2014). Consistent with the fact that the vast majority of the global population live in LMICs, the recent WHO publication stated that 75.5% of suicides occur in LMICs (WHO 2014). China and India account for approximately 30% and 20%, respectively, of global suicide mortality (Phillips et al. 2002; Kumar

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[1] The characterisation of a country's economy as low and middle income is based on the World Bank's annual computation of a country's Gross National Income (GNI) per capita, the computation carried out through the use of the World Bank Atlas method (World Bank 2013a). The current chapter uses the World Bank's 2013 country income-level classifications. The 2013 classifications are low income, US$ 1035 or less; lower-middle income, $1036–$4085; upper-middle income, $4086–$12,615; and high income, $12,616 or more (World Bank 2013a). The present chapter therefore focuses on all countries with GNI per capita not exceeding $12,615 per the 2013 classification.

et al. 2013). In China, a study of a six-year (2004–2010) trend of injury death found suicide to be the second leading cause of injury death and more significantly, the biggest cause of rural female mortality (Zhang et al. 2014). Evidence from South Africa has shown that suicide accounts for one-tenth of all unnatural deaths there (South Africa National Injury Mortality Surveillance System, 2004, cited in Mugisha et al. 2011). Ovuga (2005) also reported a high suicide rate of 16.7 per 100, 000 persons in Northern Uganda. A WHO suicide mortality database study has demonstrated that Belarus, Hungary and Latvia, all in the LMIC category, were listed among the ten countries with the highest suicide mortality rate (Värnik 2012). Belarus, for example, had a male suicide rate as high as 48.7 per 100, 000 persons (Värnik 2012). With estimates for suicide deaths, given by the WHO, to be approximately 1.53 million for the year 2020 (Bertolote and Fleischmann 2002), it has been projected that the greatest mortality burden will be felt in LMICs (Gad El Hak et al. 2009). This projection together with the foregoing evidence on the burden of suicide is alarming and provides a compelling reason for suicide in LMICs to be considered as an issue of concern.

The Need for Equity

While LMICs experience the largest suicide burden, they have the lowest resources to address this burden. This offers a cogent reason to attend to suicide in LMICs (Chisholm et al. 2007; WHO 2012). The goal is to address the gap between burden and the low amount of resources and services so as to achieve equity in health and social care (Patel 2014). To effectively scale up health and social care, sound evidence derived from research is required (Chisholm et al. 2007). However, this critical evidence base is particularly lacking in LMICs as research on suicide is scant (Patel and Kim 2007; Vijayakumar 2004; WHO 2007). The paucity of research is highlighted in the discovery that although 85% of global suicides occur in LMICs, less than 10% of suicide-related research is carried out in these contexts (Phillips 2004). This gap in evidence has translated into a scarcity of suicide prevention measures in LMICs (Gureje et al. 2007). Besides, it cannot be assumed that research evidence from HICs may be valid and applicable to LMICs in light of the substantial economic and sociocultural differences between HICs and LMICs (Phillips 2004; Vijayakumar et al. 2005). This makes it imperative for LMICs' research to generate evidence that would be applicable and possesses what Jacob (2012) terms as 'goodness of fit' in the LMICs' context. In line with the need for equity, this chapter provides evidence to drive and inform suicide prevention and intervention in LMICs and second, contributes to bridging the evidence base gap for LMICs in the mainstream suicidology literature.

Theoretical Models for Suicide

It is widely acknowledged that suicide is a complex multifactorial phenomenon which does not lend itself to a single-factor explanatory account (Adinkrah 2012; Gureje et al. 2007; Hawton and van Heeringen 2009; WHO 2012). As such, the socio-ecological model is adopted as the framework to articulate the complexity and multidimensionality of its risk factors. This model is premised on the assumption that human development is a two-way interaction between the person and the characteristics of the environment in which they develop (Brofenbrenner cited in Crosby et al. 2011). Owing to this assumption, a key strength of the socio-ecological framework is its emphasis on the synergistic impact of many interacting factors in bringing about an outcome (Crosby et al. 2011; Patel et al. 2014). The socio-ecological model thus embodies a complex and a non-linear web of relationships between three levels: intrapersonal, interpersonal and distal (Patel et al. 2014). *Intrapersonal* factors dwell on person-centred risk factors such as genetic make-up, personality characteristics, physical health, emotions and self-concept. At the heart of the *interpersonal* level are social relationships that shape social identity (McLeroy et al. 1988). These relationships occur in the immediate contexts of family, peer group, schools, workplaces and communities and as such are sometimes called proximal processes (Patel et al. 2014). Factors residing in these contexts could pose risks of suicide as they are the sources of daily interpersonal interactions. *Distal* factors are risk determinants at the more remote macro-level, such as regional, national or global forces. Key examples include socio-economic policies, political climate and other prevailing structural elements.

Research Approaches to Ascertaining and Investigating Death by Suicide

It has been argued that the *psychological autopsy* method represents the most comprehensive method of investigating completed suicides (Mościcki 2001). The psychological autopsy method is a retrospective procedure involving the use of structured interviews with the decedent's relatives and friends together with the evaluation of health and medical records in order to construct narratives about the antecedents of a suicide (Cavanagh et al. 2003; Isometsä 2001; Mościcki 2001). These relatives and friends act as proxy participants[2] and thus represent the actual suicide decedents identified for investigation. Research investigating psychological autopsies often employs *case-controlled* designs. Vijayakumar et al. (2005) argue that case-controlled design represents the most methodologically sound design for studying suicide risk factors as it delineates exposure variables that contribute to determining the outcome of interest (suicide) as there is a comparison between those who have demonstrated the outcome (case) and an identical group (control) that has not demonstrated the outcome. However, there are, of course, variations in the levels of methodological rigour within the body of research using this approach.

Research Investigating Suicide in LMICs

This chapter is grounded in a systematic review of case-controlled psychological autopsy studies conducted in LMICs (Boahen-Boaten 2014). The relevant literature for the systematic review was based on the following inclusion and exclusion criteria.

Studies were included if they were

- Conducted in a country classified as low income or middle income on the basis of the 2013 World Bank country income-level classification (World Bank 2013b).
- Published from 2004 through to 2014.
- Reported in the English Language.
- Aimed primarily at identifying suicide risk factors.
- Conducted through a psychological autopsy method.
- Conducted utilising a case-controlled study design.
- Published in a peer-reviewed journal.

Studies were excluded if they were

- Targeted at special populations on the basis of gender, occupation and clinical diagnoses.
- Based on secondary analysis of psychological autopsy data.
- Postgraduate theses or dissertations.
- Review and theoretical papers.
- Not exclusively focused on completed suicides.

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[2] Proxy participants refer to the informants who are interviewed upon which impressions are formed about the lifestyles, living circumstances, personalities, physical and psychological health of the actual suicide decedent cases (and controls) (Hjelmeland et al. 2012; Sher 2013).

Search Strategy

The databases PsycINFO, CINAHL, PsychArticles, MEDLINE, Anthropology Plus, Psychology & Behavioural Sciences Collection, SOCIndex and ATLA Religion Database; PUBMED; Web of Science; SCOPUS; Cochrane Library; EMBASE; and GoogleScholar were searched. The electronic database searches ended on 29 June 2014. Reference lists of the selected studies were searched for additional studies that met the inclusion criteria.

The Preferred Reporting Items Systematic Reviews and Meta-Analysis (PRISMA) guideline specifies that search terms used should be reported (Moher et al. 2009). Searches were conducted using the combination 'Completed suicides' **AND** 'risk factor' **OR** determin* **AND** 'Developing countries', 'suicide risk factors' **AND** 'psychological autopsy' **AND** 'low and middle income countries'. Limiters applied in the EBSCO searches included Scholarly (Peer Reviewed) Journals; English Language; Research Article; Publication Type: Academic Journal; Language: English; Apply related terms; Exclude dissertations; Exclude Book Reviews; Exclude Non-Article Content; Year of Publication, 2004–2014.

Figure 17.1 provides details about the number of studies identified and retained at each stage of the literature search. The literature search yielded 16 eligible studies.[3] Table 17.1 summarises information on the various risk factors identified by these studies.[4]

Suicide Risk Factors

The risk factors for suicide across the reviewed studies were identified in narrative synthesis fashion. These identified risk factors sit at different levels of the socio-ecological model (Patel et al. 2014). In the first place, *intrapersonal* factors—namely impulsivity, poor coping skills, hopelessness, personal or family

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[3] All the studies were conducted in middle-income countries {MIC}. Twelve of the studies were conducted in upper-middle-income countries: eight studies were from China (Fang et al. 2012; Kong and Zhang 2010; Li et al. 2008; Zhang et al. 2010, 2011, 2013, 2004; Zhang and Wang 2012), two were conducted in Hungary (Almasi et al. 2009; Zonda 2006), one from Colombia (Palacio et al. 2007) and one from Turkey (Altindag et al. 2005). The remainder were conducted in lower-middle-income countries: two from India (Gururaj et al. 2004; Manoranjitham et al. 2010), one from Indonesia (Kurihara et al. 2009) and one from Pakistan (Khan et al. 2008).

[4] Table 1 displayed multivariate data on suicide risk factors extracted from the reviewed studies on the basis that multivariate analysis yields outcomes with independent influence in the interactive context of multiple variables (see: Roberts and Browne 2011; Cheng et al. 2000). In a study with no such multivariate data provided, the risk factors highlighted from its analysis were extracted.

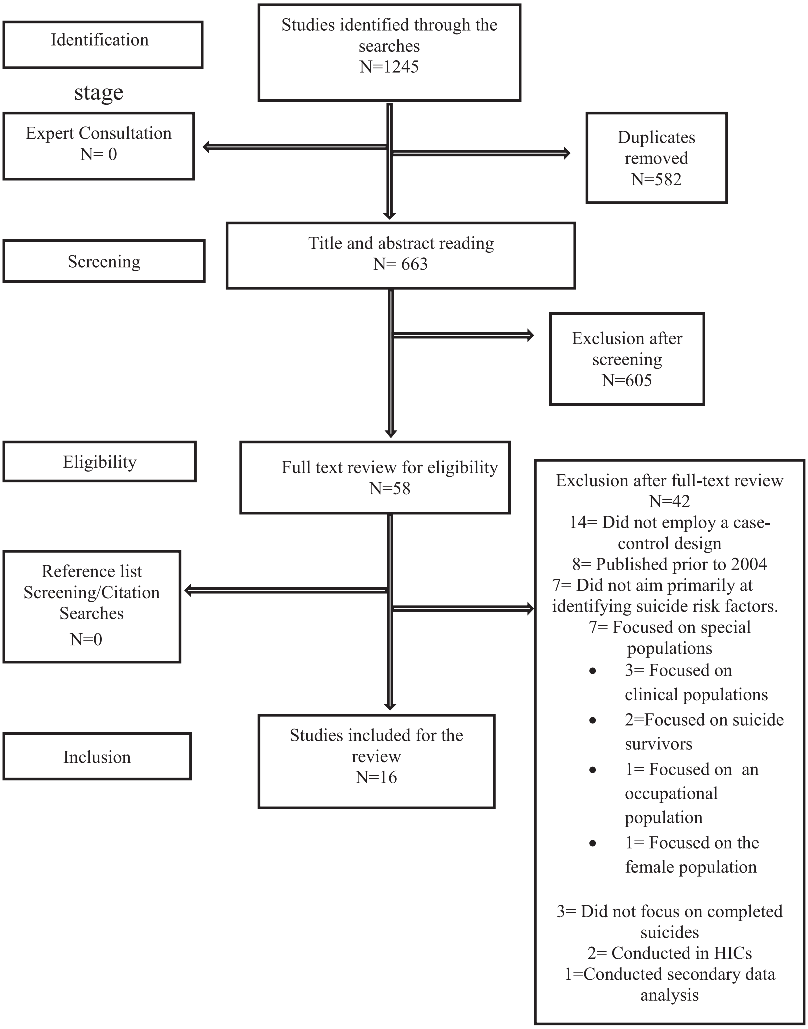

Fig. 17.1 Study flow diagram, showing the results of the searches for this review

history of suicide and high neuroticism in interaction with low extraversion—predicted suicide risk in middle-income counties (MICs) (Fang et al. 2012; Palacio et al. 2007; Zhang et al. 2010, 2011; Zonda 2006). Mental ill-health, manifested predominantly through mood and affective disorders, alcohol and/or substance use disorders, personality disorders, schizophrenia and psychotic disorders and anxiety disorders, was implicated in suicide risk (Almasi et al. 2009; Altindag et al. 2005; Gururaj et al. 2004; Khan et al. 2008; Kurihara et al. 2009; Li et al. 2008; Manoranjitham et al. 2010; Palacio

Table 17.1 Selected studies reporting the risk factors for suicide in LMICs

Study	Country	Sample	Risk factors for suicide	Results Odds ratio	95% CI	*p*-value/ Significance level
Almasi et al. 2009	Hungary	194 suicide cases, 194 controls (matched for age, gender and general practice)	Current affective disorder	10.94	3.84–31.12	<0.001
			Alcohol/drug related disorder	3.34	1.28–8.76	0.01
			Current smoker	2.85	1.21–6.74	0.02
			Single, separated, divorced or widowed	2.63	1.03–6.70	0.04
			Not being out socially in last month	5.01	2.23–11.25	<0.001
			No education beyond 16 years of age	3.71	1.07–12.81	0.04
			Major life event during the last 3 months	4.29	1.77–10.41	0.001
Altindag et al. 2005	Turkey	26 suicide cases, 25 controls (matched for age, gender and marital status)	To be illiterate	0.93	0.30–2.82	0.90
			Not in paid work	3.00	0.52–17.15	0.20
			Life events in last week	13.63	3.18–58.34	<0.001
			Current mental illness			
			Any mental illness	3.37	1.06–10.71	0.03
			Severe mental illness	9.91	2.59–37.87	< 0.001
Fang et al. 2012[a]	China	64 suicide cases, 64 living controls (matched for age, gender and geographic location)	Low neuroticism and low extraversion	0.48	0.18–1.30	0.144
			High neuroticism and low extraversion	3.07	1.44–6.55	0.003
			Low neuroticism and high extraversion	0.41	0.18–0.92	0.029
			High neuroticism and high extraversion	1.10	0.47–2.57	0.828

Study	Country	Sample	Risk factors for suicide	Results Odds ratio	95% CI	*p*-value/ Significance level
Gururaj et al. 2004	India	269 cases, 269 controls (matched forage, gender and neighbourhood)	Access to resources in crisis situation	11.47	4.56–28.82	0.241
			Alcohol abuse	4.86	1.85–12.82	0.001
			Lack of social support	3.04	1.09–8.48	0.034
			Emotional abuse	2.65	0.12–56.23	0.531
			Physical abuse	1.84	0.42–8.07	0.419
			Mental illness	1.63	0.39–2.46	0.962
Khan et al. 2008	Pakistan	100 suicide cases, 100 living controls (matched for age, Gender and area of residence)	**Educational attainment**			
			No formal education/primary	4.9	0.8–29.8	–
			Secondary and above	1.0		–
			Marital status			
			Never married	1.0		–
			Ever married	3.6	0.6–22.3	–
			Depression			
			No	1.0		–
			Yes	208.3	11.0–3935.2	–
Kong and Zhang 2010[b]	China	370 suicide cases, 370 living controls (matched for age, gender and location of residence)	One or more pesticide at home	1.95	1.33–2.85	0.001
			Insecticide at home	1.92	1.26–2.91	0.002
			Herbicide at home	0.78	0.41–1.49	0.456
			Bactericide and rodenticide at home	0.99	0.22–4.41	0.987
			Other pesticides at home	1.16	0.61–2.20	0.653
Kurihara et al. 2009	Indonesia	60 suicide cases, 120 living controls (matched for age, gender and village of residence)	At least one psychiatric diagnosis	14.84	6.12–35.94	<0.001
			Low level of religious involvement	7.24	2.28–22.95	<0.01
			Severe interpersonal problems	3.86	1.36–11.01	<0.05

(*continued*)

Table 17.1 (continued)

Study	Country	Sample	Risk factors for suicide	Results Odds ratio	95% CI	*p*-value/ Significance level
Li et al. 2008	China	114 suicide cases, 91 injury death controls (matched for gender and nature of death-sad and unexpected)	Lived in villages (versus cities, suburbs or towns)	3.4	0.9–12.3	–
			Experienced severe life event in the last two days before death	31.8	2.6–390.6	–
			Had any depressive symptoms two weeks prior to death	21.1	4.6–97.2	–
			Low quality of life score in month before death (<66, range 0–100)	9.7	2.8–34.1	–
			Acute stress score at time of death			
			Lowest tertile	1.0	–	–
			Middle tertile	3.1	0.8–11.9	–
			Highest tertile	9.1	1.2–66.8	–
			Gender (Male vs. Female)			
			Not meet psychiatric criteria at time of death	54.6	(9.5–315.6)	<0.001
			Met psychiatric criteria at time of death	1.3	0.1–12.8	0.837
			Met psychiatric criteria at time of death	4.7	1.2–18.6	–
			Female	0.3	0.0–3.6	0.361
			Male	14.0	2.6–76.5	0.002
Manoranjitham et al. 2010	India	100 suicide cases, 100 living controls (matched for gender, age and neighbourhood)	On-going stress	98.2	(27.9–345.8)	–
			Chronic pain	40.0	3.0–537.8	–
			Any psychiatric diagnosis	2.8	0.95–8.2	–

Study	Country	Sample	Risk factors for suicide	Results Odds ratio	95% CI	*p*-value/ Significance level
Palacio et al. 2007	Colombia	108 suicide cases, 108 decedent controls (matched for age and gender)	Adverse life events in the previous six months	11.81	4.29–32.52	<0.001
			Antecedents of suicide in the family	10.82	2.23–52.47	0.003
			Major depressive episode	4.58	1.53–13.67	0.006
			Expression of a wish to die	3.54	1.25–10.06	0.017
Zhang et al. 2004[a,c]	China	66 suicide cases and 66 living controls (matched for age, gender and location)	Marital status	–0.005	–	–
			Education	–0.015	–	–
			Family annual Income	–0.040	–	–
			Employment	–0.042	–	–
			Physical health	0.225	–	<0.01
			Mental disorder	0.266	–	<0.01
			HAMD depression	0.330	–	<0.01
			Religion			
			No religion	0.003	–	–
			Belief in god	–0.133	–	–
			Belief in afterlife	0.052	–	–
			Social support			
			Interactive	–0.209	–	<0.01
			Perceived	–0.170	–	<0.05
			Instrumental	–0.048	–	–
			Negative life events	0.147	–	<0.05
Zhang et al. 2013[b]	China	392 suicide cases and 416 living controls (matched for age, gender and area of residence)	Age	–	–	–
			Education years	0.79	0.73–0.86	<0.001
			Family annual income			
			Low (RMB<10,000)	1	–	–
			Middle (10,000 ≤ RMB ≤ 20,000)	0.70	0.45–1.08	0.108
			High (RMB>20,000)	0.47	0.27–0.82	0.008
			Negative life events	1.56	1.42–1.73	<0.001
			Aspiration Failed	3.71	1.98–6.94	<0.001
			Nagelkerke R^2	0.395	–	–

(*continued*)

Table 17.1 (continued)

Study	Country	Sample	Risk factors for suicide	Results Odds ratio	95% CI	*p*-value/ Significance level
Zhang et al. 2011[b]	China	392 suicide cases and 416 living controls (matched for age, gender and area of residence)	Education level (<7 years)	1.9		0.066
			Marital status			
			Never married and not dating	1		
			Never married but dating	4.8		0.003
			Ever married	0.8		0.643
			Low family annual income	1.9		0.075
			Party/League membership	0.4		0.004
			Relationship with parents (poor)	2.0		0.080
			Suicide history in family	4.6		0.004
			Negative life events			
			0–1	1		
			2–3	2.4		0.009
			4 and over	5.5		<0.001
			Perceived social support (low)	2.5		0.009
			Mental disorders	16.8		<0.001
			Hopelessness (High)			<0.001
			Approach coping (low)	3.3		<0.001
			Dysfunctional impulsivity	2.2		0.008
Zhang and Wang 2012[b]	China	392 suicide cases and 416 living controls (matched for age, gender and area of residence)	**Community-level stress**			
			Individual behavioural problems (e.g. alcohol abuse)	1.25	–	0.002
			Social structural stresses (e.g. health care, job security, family dispute and transportation)	1.10	–	0.012

(*continued*)

Table 17.1 (continued)

				Results					
				Females			Males		
Study	Country	Sample	Risk factors for suicide	Odds ratio	95% CI	*p*-value/ Significance level	Odds ratio	95% CI	*p*-value/ Significance level
Zhang et al. 2010[b]	China	392 suicide cases and 416 living controls (matched for age, gender and area of residence)	**Age**						
			<25	1.0	–	–	1.0	–	–
			≥25	1.106	–	0.799	1.660	–	0.246
			Education (years)						
			<7	1.0	–		1.0	–	
			≥7	0.493	–	0.033	0.0223	–	<0.001
			Family annual income						
			Low (RMB<10,000)	1.0	–	–	1.0	–	–
			Middle (10,000<RMB<20,000)	0.717	–	0.363	0.715	–	0.390
			High (RMB>20,000)	0.528	–	0.096	0.294		0.002
			Marital and dating status						
			Never married and no dating	1.0	–	–	1.0	–	–
			Never married but dating	3.205	–	0.038	1.673	–	0.312
			Ever married	0.771	–	0.550	0.401	–	0.047
			Religiosity	1.756	–	0.081	2.209	–	0.063
			Pesticide stored at home	1.192	–	0.579	1.329	–	0.421
			Traditional gender value		–	–	–	–	–
			Low	1.0	–	–	1.0	–	–
			Middle	0.842	–	0.629	1.250	–	0.603
			High	1.035	–	0.955	2.936	–	0.096
			Modern gender value						
			Low	1.0	–	–	1.0	–	–
			High	1.026	–	0.946	0.506	–	0.073
			Gender value strain						
			Low	1.0	–	–	1.0	–	–
			High	2.907	–	0.023	1.140	–	0.771
			Impulsivity						
			Low	1.0	–	–	1.0	–	–
			High	6.231	–	<0.001	4.076	–	<0.001
			Mental Disorder	32.371	–	<0.001	43.369	–	<0.001

(*continued*)

Table 17.1 (continued)

Study	Country	Sample	Risk factors for suicide	Results Odds ratio	95% CI	*p*-value/Significance Level
Zonda 2006	Hungary	100 suicide cases, 100 decedent	**Psychosocial stresses**			
			Death oppressive experience in the previous month	3.08	1.59–5.96	0.001
			Interpersonal problems	3.16	1.69–5.89	<0.001
			Financial difficulties	1.48	0.83–2.66	0.236
			Clinical characteristics			
			Previous suicide attempt	2.27	1.10–4.65	0.035
			1 attempt	1.17	0.37–1.94	0.833
			2 or more attempts	16.39	2.11–125	0.001
			Behaviour changes in month before death	2.86	1.48–5.55	0.002
			Verbal hints about death in month before death	1.99	1.01–3.92	0.064
			Psychiatric disorders at time of death			
			Major depression	2.74	1.41–5.32	0.004
			Alcohol dependence/abuse	0.54	0.30–0.97	0.058
			Drug and/or medication dependence/abuse	1.87	0.74–4.68	0.258

[a] Originated from one dataset

[b] Originated from one dataset

[c] Multivariate analysis results were regression co-efficient NOT odds ratio RMB, Chinese Renminbi (US$1 ≅ 7.00 RMB)

et al. 2007; Zhang et al. 2010, 2011, 2004; Zonda 2006). Being a female with no psychiatric history conferred suicide risk in China (Li et al. 2008). Physical ill-health predicted suicide risk (Manoranjitham et al. 2010; Zhang et al. 2004). Failed aspirations and the concurrent belief in two conflicting values predicted suicide risk (Zhang et al. 2010, 2013).

At the *interpersonal* level, interpersonal difficulties (mainly marital disputes, abuse and family conflicts) constituted the most significant life events that conferred suicide risk particularly for females (Almasi et al. 2009; Altindag et al. 2005; Gururaj et al. 2004; Kurihara et al. 2009; Li et al. 2008; Manoranjitham et al. 2010; Palacio et al. 2007; Zhang et al. 2011, 2004; Zonda 2006). Loss events particularly through death and socially disgraceful ('loss of face') circumstances were also risk factors for suicide (Li et al. 2008; Palacio et al. 2007; Zhang et al. 2004; Zonda 2006). Poor social support or social isolation posed suicide risk (Almasi et al. 2009; Gururaj et al. 2004; Zhang et al. 2011, 2004). Both religiosity and marriage yielded mixed results. Regarding religion, whereas in the Indonesian study by Kurihara et al. (2009) low religiosity predicted suicide, Zhang et al. (2010) reported the converse in China—where high levels of religiosity predicted suicide risk. For marriage, Khan et al. (2008) found that suicide decedents in Pakistan were more likely to be married, whereas the Hungarian study by Almasi et al. (2009) reported that being unmarried was associated with suicide risk. Verbal expression of suicidal thoughts was observed to predict completed suicide (Palacio et al. 2007; Zonda 2006).

At the more remote *distal* level, it was found that lack of or low education, economic and employment difficulties increased the probability of suicide occurrence (Almasi et al. 2009; Altindag et al. 2005; Khan et al. 2008; Zhang et al. 2010, 2011; Zhang and Wang 2012; Zonda 2006). Rural residence constituted an independent risk factor for suicide in India (Li et al. 2008). Further, communities with structural constraints in areas such as healthcare and transportation together with behavioural problems such as alcohol abuse posed high suicide risk (Zhang and Wang 2012). Access to means of suicide and limited resources for crisis management increased suicide risk (Gururaj et al. 2004; Kong and Zhang 2010).

The research findings from MICs on suicide attempts, family history of suicide, impulsivity, hopelessness and physical ill-health predictive of suicide risk are consistent with existing empirical evidence from both HICs and LMICs that found associations between these intrapersonal characteristics and suicide risk (Brezo et al. 2006; Cavanagh et al. 2003; Cheng et al. 2000; Conner et al. 2001; Hirvikoski and Jokinen 2012; O'Connor and Nock 2014). Further, the finding that high neuroticism interacts with low extraversion to confer suicide risk appears to be supported partially by previous research that found neuroticism and extraversion as personality traits, which confer suicide risk (Brezo et al. 2006; Hirvikoski and Jokinen 2012). A line of thought to account for suicide risk predicted by discordant beliefs and goal failure is the psychological strain theory. According to Zhang et al. (2010), concurrent beliefs in two conflicting values create value tension within the individual, and the resulting stress of this tension puts the individual at risk of suicide. As regards goal failure, Zhang et al. (2013) argue that inability to fulfil an aspiration leaves the individual in an unfulfilled state creating a sense of strain which heightens the risk for suicide.

The finding that mental illness, presented through the diagnoses of depressive and affective disorders, alcohol/substance abuse, personality disorders and schizophrenia, is a major risk factor for suicide is supported by empirical studies from both LMICs and HICs which provide evidence that these psychiatric conditions confer suicide risk (Abeyasinghe and Gunnell 2008; Cavanagh et al. 2003; McLean et al. 2008; Vijayakumar and Rajkumar 1999; Yashimasu et al. 2008). Psychiatric disorders conferred varying degrees of strength in determining suicide risk in different settings. For example, whereas Khan et al. (2008) reported depression in approximately 80% of the Pakistani suicides, Zhang et al. (2010) found that less than 50% of Chinese suicides were mental health-related. These predictive strength differentials bring to the fore the need for a nuanced understanding about suicide risk in a particular context (WHO 2014).

The findings that interpersonal distress and social isolation influence suicide risk lend credence to Durkheim's (1951) social integration theory. This theory suggests that suicide risk is heightened when there is a breakdown of social ties between the individual and the social group. The research reviewed in this chapter also highlighted that shame predicts suicide risk. Shame results in 'loss of face', or *diu mianzi* as the Chinese call it, and it damages the individual's reputation in the social context (Heine 2008; Zhang et al. 2004). Thus in a person's bid to protect their 'face' from dishonour, suicide becomes appealing (Zhang et al. 2004).

The finding that religion carries both risk and protective implications on suicide is linked to the social status of religion in the different contexts. Low or no religiosity was found to confer suicide risk in Indonesia. Evidence shows that more than four-fifths of the Indonesian population subscribe to Islam (Buehler 2009). As a religion, Islam strongly prohibits self-killing (Vijayakumar et al. 2008). Thus, religious people in Indonesia are more likely to be protected from suicide by Islam's doctrine on suicide and the social capital Islam offers as the majority religion. It can therefore be speculated that low or no religiosity in that context can lead to social exclusion and heighten suicide risk. By contrast, Zhang et al. (2004) maintained that religious practice is relatively uncommon among the majority in China. Religious people are thus regarded as deviants and exposed to the stress of marginalisation. In the same vein as religion, marriage was evidenced to confer contradictory influence on suicide risk in different settings. The finding that marriage poses risk for suicide in Pakistan is consistent with the observation by Khan and Reza (2000) that marriage constitutes a source of considerable stress particularly for women, who are usually faced with stressors such as conflict with in-laws and spousal abuse making them vulnerable to suicide. On the contrary, the finding in Hungary that being unmarried poses suicide risk corresponds with the evidence by Bálint et al. (2016) that marriage there significantly diminishes suicide risk as it offers a buffer against stress.

The findings that unemployment, employment and financial difficulties, low education and community challenges in healthcare and transportation increase suicide risk appear to support claims that suicide is not just an individual personal act, but instead suicide can occur in the context of a 'basic flaw in the social fabric' (Durkheim 1951, p. 17). Durkheim (1951) argues that suicide is not simply a personal choice an individual makes in response to stress but also a phenomenon which reflects social constraints or turbulences in institutions or structures (e.g. employing organisations, educational institutions and social providers) meant to buffer the individual against stress. Thus suicide, though it results in an individual's death, occurs in the context of broader social factors. The finding that rural settlement is a suicide risk factor corresponds with the argument by Vijayakumar et al. (2008) that rurality confers suicide risk in developing Asian countries with huge rural populations. A possible explanation offered by these researchers is that rural areas, where the predominant occupation is farming, come with distresses and strains such as flood, droughts and fires that cause hardships and make rural life difficult. These hardships may be compounded by the easy availability or access to highly lethal substances (pesticides) and the scarcity of support services and crisis management resources in the rural contexts, which translate impulsive suicidal behaviours into fatal acts (Eddleston and Phillips 2004). Importantly, these complications of access to pesticides and limited resources for crisis management were identified in the present chapter as independent risk factors for suicide.

Ethnographic Insights into Suicide in China and India

Suicide as a complex, multifactorial phenomenon carries different understandings and meanings in different cultural contexts (Staples and Widger 2012). The culture-specific meanings of suicide make evidence from ethnography, a qualitative research approach which details a particular cultural group's views, perspectives and realities about a phenomenon (Quimby 2006), crucial to understanding the complexities of suicide. This section therefore offers ethnographic insights into suicide in China and India, the two most populous nations in the majority world (LMICs) who together bear approximately half of the entire global burden of suicide (Kumar et al. 2013; Phillips et al. 2002).

Consistent with the finding in the present chapter that being a female in the Chinese context is a suicide risk factor, it has been revealed that the high prevalence of suicide among females (in particular married females) sits in the broader context of the inferior status women occupy in patriarchal Chinese society (Meng 2002; Zhang 2010). In an engaging ethnographic inquiry, Meng (2002) recorded the marital abuse and familial conflicts with the in-laws of a woman suicide decedent (named as 'Fang') to highlight the significance of family abuse and neglect in female suicide in the rural Chinese context. As the narration by Meng (2002) went, the parents of both spouses were against her marriage. This situation brought about significant tension in the woman's relationship with her in-laws, which sometimes degenerated into verbal exchanges. The woman felt isolated as her husband usually took sides with his parents and her own family had also withdrawn their social support for her due to her decision not to follow the 'arranged marriage' system. The strained ties with her in-laws and husband together with the loss of support from her own family conferred considerable stress on her and put her at a great social disadvantage. In this patriarchal and oppressive sociocultural environment, women are further pressured to stay in conflictual and abusive relationships. It has been suggested that in such situations of oppression and marginalisation of Chinese women, suicide became a powerful tool for them to protest their oppressed positions, exact revenge and to redefine their positions (Meng 2002). Meng (2002) hypothesises that the woman, through suicide, changed the nature of her social relationships and further forced the in-law family, according to rural sociocultural norms, to respect and accord her an honourable funeral to avoid social stigma. Meng (2002) interpreted this as an act of revenge being bestowed upon the in-law family, although it remains unclear whether this was a primary motivation at the time of the woman's death. As such, through suicide, the woman achieved a desirable and privileged status that she had failed to achieve while living. Although this ethnographic insight is based on a single story and may not be representative of all rural Chinese female suicides, it nonetheless gives an idea of how suicide in the rural Chinese context can be strongly linked to strained family ties.

Münster (2015), through his ethnographic research, conceptualised three agentive discourses to account for farmer suicides in the Wayanad District in Southern India: victimhood, voice and responsibility. In relation to victimhood, suicide was presented as the outcome of an exploitative system that puts farmers at a great economic disadvantage. Attempts were made to connect farmers' suicides with staggering debts and landholding systems. The media was largely responsible for advancing this narrative through the broadcasting and publications of sensational stories and alarming statistics on suicide to demonstrate intricate links between suicide, global trade forces and farmers' distress occasioned by crippling debts. Thus in this narrative, farmers were presented as victims who are compelled by crisis and distress, emanating from unfair and exploitative agrarian structural systems, to kill themselves.

Another narrative line of suicide in the Wayanad District was the conceptualisation of suicide as a form of political communication, given that suicide constitutes an integral and a firmly rooted part of expressing protest or dissent in South Asia. This is the narrative of suicide as 'voice'. Suicide featured strongly in farmers' unrest in the mid-2000s in relation to calls for government interventions. Indeed, Münster (2012) placed the high rate of suicide among rural farmers in the broader context of the state's scant attention to the agrarian crisis. Farmers' suicides thus represent 'an important reminder of a neglected strand of the identity of India's postcolonial state- India as an agrarian country, as a nation with majority of rural citizens' (p.183). Through suicides, therefore, Indian farmers attained the state's attention to roll out interventions and relief measures to address the agrarian crisis.

The most predominant and the third line of discourse Münster (2015) discerned about farmer suicides in Wayanad is the narrative which emphasises the individual and collective roles the farmers played in the onset of the agrarian crisis which plunged many of them into suicide. This is the narrative of responsibility. This narrative holds that the shift from subsistence farming to commercial crops led to the violation of the moral idea of farmers' responsibility for the agro-environment. Most of the famers engaged in monocropping of cash crops such as pepper and banana and excessively applied chemicals to increase their yields, actions which constituted violations of the rural moral economy. The expectations of large profits from the harvest of the cash crops convinced some farmers to access loans to engage in luxurious activities and lavish lifestyles such as building of new houses. As it turned out, the expectations of these farmers failed to materialise due to factors including macro-level trade factors and uncertain climatic conditions. Many farmers became severely stressed as they were confronted with massive debts and thus drifted towards suicide. Another dimension of this discourse on responsibility is the uncertainty and pessimism farmers harboured on a collective level about the continued ability of Wayanad to support their agricultural work, which was the source of their livelihood, due to massive decline in arable lands. The situation of decline in arable lands was attributed to the unrestrained application of chemicals on farms, fungal diseases and farm raids by wild animals removed from their natural habitats. These frustrations and existential anxieties found expressions in suicide. Suicide therefore represented a backlash of the infraction of the moral code and principles about farming and offered a moral context by which Wayanad farmers in South India contemplated deeply about their agrarian practices, beliefs and conduct.

Jocelyn Chua (2014) has sought to offer a more expansive view of the socio-cultural context of suicide in the Kerala state in South India. Kerala presented a paradox. On one hand, Kerala has experienced rapid and massive socio-economic transformation and has been lauded as a 'Model of Development' in India. On the other hand, Kerala has earned the unenviable tag of India's 'suicide capital'. Drawing on the insights from her ethnographic inquiry in the southern Indian state of Kerala, Chua revealed how suicide offered a window to understand the perils that come along with modernity in that it offers an escape route from the consumerist pressures that 'modern' living presents for those whose demands, pursuits and aspirations for good living are thwarted.

In a related article, Chua (2012) identified different social class-dependent narratives that are usually invoked to interpret suicide or dismiss a death as a suicide event in Kerala. It was recognised that the educated middle class were fluent in and employed the official state and bureaucratic categories in which death events were interpreted in relation to demographic trends of suicide. For example, the death of a young man from a middle-class family led the uncle of the decedent to draft a carefully constructed memo about the death of his nephew (named Biju) to refute compelling evidence gathered by the police and the post-mortem to suggest that the young man had taken his own life. The information presented in the memo was arranged in three sections: 'Academic' (e.g. Biju's exemplary academic record), 'Financial' (e.g. the absence of any debt) and 'Physical' (Biju's 'handsome' physical appearance leading to no obvious 'confidence issues', no recent ending of 'love affairs'), and was used as an explanation of how the death could not have been due to suicide but instead must have been due to homicide. Chua (2012) noted that the structuring of the information in the memo (academic, financial and physical) overlapped with reasons enumerated by the state for suicide for example, 'bankruptcy or sudden change in economic status', 'failure in examination' and 'failed love affair'. Chua (2012) reflected on the apparent power that these categorical factors had for being considered to be *sufficient* reasons for suicide and the way in which Biju's family were at pains to include in the memo details about his life that ran contrary to characteristics that were deemed prototypical of young men who complete suicide. Chua (2012) concluded that the case of Biju highlighted the 'tacit but sometimes conflicting ways social and bureaucratic discourses render death events imminently knowable. [And the] … abilities of the educated elite to deploy this knowledge toward particular ends in deciphering suicide' (p. 241).The research illustrates how a family's efforts to advance a narrative concerning the 'why' of a suicide can hinge on the family's implicit desire to avoid social blame for the suicide event. Chua (2012) suggests that this desire can cause families to disregard expert and vernacular narratives that conflict with their (family's) own understandings of the death and also put the families in bad light.

Together, these ethnographic insights from both China and India reveal that in different sociocultural spaces, different discourses and narratives are generated to make meaning of the complex phenomenon of suicide. The possibility is raised that suicide may not necessarily be a negative, self-destructive act always but also a culturally validated behaviour executed to achieve social goals or reshape social relationships. This serves to broaden and diversify mainstream narratives, which hinge largely on Western-originated ideas of suicide as an individual act of self-destruction attributable to neurobiological and psychological mechanisms. In addition, the ethnographic work in India demonstrated how families with comparatively high levels of education can be guided by State-endorsed explanations for suicide to gather evidence aimed at refuting suggestions that a death was due to suicide and minimise the risk of social blame.

Critical Appraisal of the Strength of the Evidence

In the research investigating suicide in MICs, suicide cases were identified largely through recorded data such as police records. Manoranjitham et al. (2010) have challenged the reliability of police records by pointing out that police records understate suicide incidence particularly when mental ill-health had not been observed. This highlights potential threats to the validity and reliability of the evidence in this chapter as it remains questionable whether the reviewed studies, including those using recorded data, are truly representative of suicides in MICs. Nonetheless, Manoranjitham et al. (2010) demonstrated through their study that a community surveillance system, which involves local people in the monitoring and reporting of suicide cases, produces a truer picture of the prevalence of suicide cases in the community which in turn improves the identification of suicide cases for research. The constraints of reporting and recording of suicide should therefore be borne in mind when interpreting such studies.

There were differences in the selection methods of suicide cases and controls. A major selection method for the suicide cases was consecutive selection in which successive suicide cases were included for study, whereas random selection was mainly employed for recruiting the controls in majority of the studies. For example, both studies by Kong and Zhang (2010) and Kurihara et al. (2009) employed consecutive selection for suicide cases as against random selection for controls. The lack of standardisation in the selection methods of cases and controls potentially introduces bias and ultimately affects the validity and reliability of findings made (Sutton-Tyrrell 1991). Importantly, the differences in the selection methods of suicide cases and controls bring to the fore the challenges inherent in the practical conduct of suicide research. For example, Almasi et al. (2009) and Kurihara et al. (2009) reported that people declined to act as proxy participants for suicide cases and controls due to the emotional distress associated with discussing the suicide death of a relative and the social stigma attached to suicide. Indeed, Almasi et al. (2009) employed two-thirds of controls acting as their own proxies due to difficulties in recruiting people as informants. In light of such challenges that apparently thwart the practical conduct of psychological autopsies, methodological compromises become necessary. Such methodological compromises as the loss of the inputs of the suicide cases and controls whose potential proxy participants declined to act as informants could have affected the gathered evidence in a systematic way.

Another critical issue to highlight is the multiplicity of the diagnostic criteria used. Multiple criteria from ICD-10, DSM IV-R, DSM IV and DSM III-R were utilised to diagnose mental disorders predictive of suicide risk across the reviewed studies. It has been noted that significant differences among these criteria in symptom definition create arbitrariness in psychiatric symptoms diagnosis (Bertolote et al. 2003). The implication is that, even subtle, differences in the constellations of diagnostic criteria employed across different studies may have served to obscure the extent to which psychiatric diagnosis is predictive of suicide risk. This impedes the development of a consistent picture about the nature and form of psychiatric symptoms predictive of suicide risk in MICs and by extension, across the globe.

Further, the psychological autopsy method represents a retrospective attempt by a third person to piece together the life of a suicide decedent (Hjelmeland et al. 2012). Such a procedure is subject to the recall or memory bias of the third-person informant (Cavanagh et al. 2003). Besides, suicide as already noted by Almasi et al. (2009) is an emotionally charged subject and may evoke profound emotions from informants. Such emotional reactions may influence, distort and consequently compromise the reliability of the information the informants give (Chachamovich et al. 2013). Altogether, the strength of the evidence on suicide risk factors contained in this chapter is subject to these methodological challenges. Caution should therefore be exercised in the extrapolation and application of the evidence contained in this chapter. Going forward, it is suggested that future case-controlled psychological autopsy studies could be improved by a clear definition of the criteria to qualify as a proxy participant. A model developed by Kraemer et al. (2003), which emphasises the selection of proxy participants based on domains of interest, provides direction in this line of research.

Implications for Suicide Prevention

The evidence that psychiatric disorders such as depression and alcohol/substance use disorder predict suicide risk (albeit at differential rates) lends support to GMH initiatives seeking to improve mental health by making mental health treatments and interventions available and accessible for everyone (Patel et al. 2014). Such mental health intervention in relation to suicide risk can involve the administration of psychotropic drugs, psychotherapy and the provision of follow-up care for those who have had prior suicide attempts (Mann et al. 2005); however, these forms of intervention should occur in the context of broader efforts to address social factors that may be contributing to suicide risk. Integrative healthcare should be promoted given the finding that both physical and mental ill-health are implicated in suicide risk. The present review's evidence that impulsivity and poor coping skills constitute risk factors for suicide highlights the need for teaching appropriate coping and life skills on how to handle crises, avoid impulsive behaviour and manage failures. The observation that interpersonal distress and social isolation contributes to suicide risk highlights the need to build social support mechanisms to intervene or prevent suicide. Takahashi et al. (2008) highlighted an intervention in China that builds on the WHO Multisite Intervention Study on Suicidal Behaviours (SUPRE-MISS), which emphasises social support for people with histories of suicide attempts to avert eventual suicide completion. The intervention consisted of regular home visits by a clinician, after a psycho-education session, to ascertain and address the suicide attempter's interpersonal conflicts. The clinician, in consultation with the suicide attempter, a confidant of the attempter called 'guardian' and close relatives, makes every effort to organise social support in the family and village for the suicide attempter. There is also scope for providing context-based education at the community and family levels to sensitise people on forms of communication of suicidal intent and additionally, raise awareness about suicide prevention resources in the community. Such enlightenment will help family and community members to identify individuals communicating suicidal intent both explicitly and tacitly and promptly guide such suicidal individuals to access suicide prevention resources in the community.

The evidence in this chapter further shows that suicide is associated with unemployment, poverty, low education, scarcity of resources to handle crises, access to means of suicide and other structural challenges in healthcare and transportation. In that regard, evidence-based macro-level policies, such as measures to restrict access to means of suicide and social welfare measures that would ease the socio-economic burden of people living in MICs, are needed. Jordan provides a reference point, as a policy there that restricted access to the use of the pesticide, Parathion, contributed to a decrease in the burden of suicide mortality particularly in the reduction of the total number of suicides by pesticide ingestion from 58 in 1978 to 10 in 1984 (Konradsen et al. 2003). Evidence from the USA shows that social intervention policies aimed at income growth, benefits for low-income people and divorce prevention were strongly related to reduction in suicide rates (Ross et al. 2012). The finding that suicide risk is heightened in the context of scanty resources to handle crises suggests that health and social welfare delivery systems should be strengthened through adequate staffing together with appropriate training of professionals on suicide risk identification, assessment and intervention. Also, the evidence that suicide risk factors differ in different contexts and that sociocultural circumstances, norms and values influence suicide suggests that there is not a one-size-fits-all approach to suicide prevention. Suicide intervention and prevention measures should be context-based and culturally informed so that they achieve the purpose for which they were designed and rolled out. Significantly, all of these initiatives will depend on the availability of adequate financial resource.

Some suicide prevention efforts have been initiated in both China and India. Both countries were integral to the setting up of the Strategies to Prevent Suicide (STOPS) project of Suicide Prevention International (SPI), which focused on the Asian region (Hendin et al. 2008). It was a multifaceted initiative that integrated multiple suicide prevention strategies and involved a mix of government and non-governmental efforts (Hendin et al. 2008). A major component of the programme was campaigns to educate the public that depression is treatable and suicide preventable. Using China as an example in this regard, a joint effort of the Ministry of Health, the Ministry of Civil Affairs, the Ministry of Public Safety and the Association for the Disabled yielded the 'National Plan for Mental Health Development from 2002 to 2010' which aimed at public education on depression and its interrelatedness with suicide (Nam et al. 2008). Another important point of focus of STOPS concerned the reporting and depiction of suicide in the media. Consistent with this approach, a non-governmental organisation called SNEHA has developed media guidelines for specifically reporting on suicide linked to failures in academic examinations in India (Beautrais et al. 2008). Besides the STOPS project, Münster (2012) reports that the Indian government instituted measures such as the National Rural Employment Guarantee Scheme and Agricultural Debt Waiver and Debt Relief Scheme, as part of broad measures to curb the agrarian crisis which was intimately linked with suicide.

Recommendation for Future Research

The absence of research from LICs casts serious doubts on the generalisability of the present evidence relating to suicide. Future research engagements on suicide risk factors should therefore focus on LICs and under-researched regions such as Africa, the Arab region, Caribbean and Latin America in order to expand the evidence base on suicide in LMICs. It will be important to investigate evidence on suicide risk factors across different geographic and socio-economic settings. This would provide a more nuanced body of evidence on suicide risk factors and would be in consonance with the emphasis by the WHO (2014) on developing contextually relevant evidence base on suicide. Further, protective factors for suicide in LMICs merit empirical attention. This would help foster the development of resilient mechanisms in LMICs as evidence shows that building protective factors against suicide is as effective as reducing risk factors (Borowski et al. 1999).

Conclusion

This chapter has reflected on research evidence relating to suicides that occur in the 'majority' world (i.e. low- and middle-income countries). There is a dearth of research investigating suicide in LICs. Evidence from MICs suggests that suicide is the consequence of the dynamic interaction of multiple factors. Psychiatric disorders (mainly depression, alcohol and substance abuse), interpersonal distress and systemic challenges such as occupational and financial difficulties are the most commonly reported risk factors of suicide in MICs. The gathered evidence indicates that factors function differently in relation to suicide determination in different settings, thus highlighting the need for consideration of cultural circumstances. Importantly, ethnographic evidence from China and India demonstrates that narratives to make meaning of suicide are situated in sociocultural circumstances and that suicide may possess utility in the pursuit of socially sanctioned goals in some contexts. Methodological complexities of the reviewed studies were noted. The arbitrary selection of proxies to act as informants for suicide cases and controls in majority of the studies reviewed represents a clear example of the methodological complexities highlighted in this chapter. What this chapter adds to the evidence base is a systematised and critical condensation of the published empirical evidence of suicide risk factors in MIC. Overall, the synthesised evidence on suicide risk factors was found to be largely consistent with existing evidence from both HICs and LMICs. Multi-sectoral engagement involving inputs from multiple and diverse areas that reflect the different socio-ecological levels of suicide risk factors is required for effective suicide prevention. Various stakeholders (including international bodies, governments, communities, families and individuals) all have key roles to play in suicide prevention efforts. Identified risk factors and methods of suicide should provide the foci and priorities to guide and inform suicide prevention measures in MICs. Nonetheless, such recommended multifaceted interventions and measures should be designed to reflect the nuances, subtleties and peculiarities of suicide in particular contexts.

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18

Anthropology and Global Mental Health: Depth, Breadth, and Relevance

Catherine Panter-Brick and Mark Eggerman

The field of Global Mental Health is rapidly developing and coalescing approaches from several sister disciplines. It is a field of research and practice, one that asks critical questions regarding the burden of poor mental health and the scope of interventions. Concerned with promoting the quality of life of people affected by mental health disorders (Patel 2014b, p. 8), it calls for concrete action to improve access to quality care for those whose needs remain unmet. A strong case has now been argued that mental health interventions:

> must go well beyond narrowly defined biomedical constructs and treatments. (Patel 2014a, p. 16)

This requires revisiting core assumptions regarding what comprises good mental health care, whether people can be helped to cope better within or outside the formal health care system, what language is most helpful to engage with communities in need, and how partnerships might best address the social contexts of mental health care. Global Mental Health demands interdisciplinary work (Patel 2014b); specifically, it requires championing a deep appreciation

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of cultural knowledge (Panter-Brick 2015) and also fostering the exchange of knowledge across cultures (White et al. 2014).

Many anthropologists have reflected on the kinds of evidence, insights, and advocacy they can offer in order to deepen our body of cross-cultural knowledge and make it more relevant to practice. For example, anthropologists are well-placed to present in-depth information on 'what truly matters' for people who are suffering mental distress or striving for wellness, living with the horrors of the past, or hoping for a better future. They present critical analyses of the upstream determinants of health inequities, namely the deep structures that are harmful or beneficial to physical, social, and mental wellbeing. They can offer sophisticated analyses of moral, social, and cultural contexts, in ways that encourage us to go beyond reductionist understandings of why they matter for health (Panter-Brick 2015; Kleinman 2006). The challenges here are to achieve a fine-grained approach to culture—defined by shared knowledge and shared expectations—to understand the foundational capacities to cope, to achieve compelling insights into the root causes of psychosocial suffering, and to promote relevant strategies for prevention and caregiving. Many anthropologists insist on a broad remit of Global Mental Health initiatives, a remit that includes efforts to promote psychosocial wellbeing and alleviate mental health distress. This takes the field of Global Mental Health beyond a singular focus on scaling-up evidence-based treatments for mental disorders (Tol et al. 2013a), demanding new strategies for sharing cross-disciplinary knowledge, and designing inter-sectoral collaborations.

Anthropological analyses provide depth and breadth of knowledge regarding the drivers of mental health and psychosocial wellness. In doing so, they offer insights that have relevant implications for the design of effective and sustainable interventions: they help us understand what are the main leverage points for creating powerful change in society and what can be transformative in health promotion and lasting in terms of intergenerational change. We present, in the body of this chapter, critical reflections on culture, resilience, and mental health from previously published work in Afghanistan (Eggerman and Panter-Brick 2014). In this work, we tried to marry different kinds of qualitative and quantitative evidence pertaining to adolescent mental health: as with cross-cultural psychiatry, medical anthropology offers a toolkit that allows researchers to draw on the power of case studies as well as the rigor of population-based surveys. We give examples below of the testimonies obtained in face-to-face interviews, of expressions of misery and dignity captured in projective drawings, and of findings obtained from robust cross-sectional and longitudinal data on mental health burden. Afghans spoke to the structural determinants of mental health distress and mental health disorders—job insecurity, housing insecurity, and the drip-drip-drip of everyday social and economic stressors that made life such a struggle to bear. They clearly identified policy initiatives that, working at a family level rather than an individual level, might well help remedy and prevent mental illness (Dari: *takleef asab*), customarily treated with blood pressure medication or 'mind syrup' providing vitamin supplementation. They emphasized the suffering that entrapped men, women, and adolescents into shame, misery, and powerlessness but also identified individual strengths, family resources, and cultural values that enabled individuals and families cope with adversity and work for a better future.

One of the important lessons drawn from this research was that a sense of *trajectory*—a sense of coherence, as well as a sense of hope—was fundamental to the struggle to be well. Poor mental health is not simply predicated on the experiences of the past but predicated on hopes and aspirations for the future. In this context, gaining a deep understanding of mental health and psychosocial wellbeing becomes a matter of understanding local *narratives of resilience*. What is resilience and how can it be documented across cultures? It could be said that narratives of resilience provide answers to the questions that hit hard when the going gets rough, questions such as 'where am I going and what resources do I have to get there?' Importantly, the individual (defined by 'I') is often embedded within a family or other social group, transforming these questions into the collective: 'where are we going?' and 'how do we access and negotiate resources?' Strong exemplars of social or collective resilience are narratives that place, over and above all other matters, the pursuit of honor and dignity in Afghanistan, of determination and social justice in Palestine, and of power and respect in inner-city America (Panter-Brick 2014). As illustrated in this chapter for Afghanistan, everyday resilience is embedded in cultural values that give promise to life. The work of identifying culturally salient notions of resilience, from in-depth qualitative research, can then be folded into mixed-method studies of epidemiological predictors (drivers) of changes in mental health over time (Tol et al. 2013b).

Anthropology provides us with a fine-grained understanding of the *cultural goals* (where we should be heading) and the *social resources* that matter to bridge hurtful gaps between present circumstances and social aspirations. A simple metaphor for culturally specific trajectories of resilience is evoked by the image of a coil (Panter-Brick 2015). At times, life feels squeezed by oppressively tightly bound coils, which can be loosened by timely action for remedial treatment or structural prevention, to turn mental health trajectories away from disorder or distress. What exactly are the coils that strangle away life, and what turning points make intervention most effective and sustainable? Studying resilience requires an understanding of the 'political economy' of health and the 'leverage points' that drive wellbeing trajectories over time.

Such analyses go beyond a functional understanding of mental health—those that conflate, for example, resilience with the absence of psychiatric pathology and the presence of psychosocial functioning. They focus on the moral, social, and structural dimensions of resilience that matter for sustaining health and wellbeing (Panter-Brick 2014). They require understanding risk and resilience as processes, not as states or traits, for navigating and negotiating resources and for building an interdisciplinary science relevant to global mental health interventions (Masten 2014; Ungar 2010; Panter-Brick and Leckman 2013).

Understanding how risk and resilience are manifested across sociocultural contexts and properly captured in longitudinal, mixed-methods research is certainly worth scholarly investment. It brings nuance and innovation to current approaches in both social sciences and global mental health. A focus of resilience invites a conceptual lens and methodological toolkit geared to understanding how people navigate the resources that matter for sustaining psychosocial wellbeing and caregiving in the local community. It goes beyond cross-sectional, epidemiological assessments of mental health burden and unmet needs for mental health care, providing a normative, interpretative framework to scientific data guiding research and practice. Insights on 'what matters' prove relevant even in cases of trauma and psychopathology. Thus post-traumatic disorder (PTSD) symptoms are governed by traumatic memories that are malleable and embedded in social experiences, rather than traumatic exposures captured as flash photographs of the past, suggesting that what matters for PTSD trajectories is interpreting, ordering, and making sense of the past to provide coherent narratives to traumatic experiences (Southwick et al. 2011; Panter-Brick et al. 2015). In settings of humanitarian crises and disasters, the field of global mental health and psychosocial support has most explicitly called for greater depth of understanding and greater relevance of critical analysis (Tol et al. 2012). Working toward the sister goals of excellence in research and relevance to practice is best advanced with a collaborative agenda, one that integrates approaches from medical anthropology and cross-cultural psychiatry to deepen and broaden the field of Global Mental Health.

Life Feeds on Hope: Family Mental Health, Culture, and Resilience in Afghanistan[1]

For many outsiders, Afghanistan encapsulates the ongoing brutality of war, the misery of poverty, and the basic violation of many human rights. Violent conflict and population displacement have disrupted access to health care,

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[1] The following text is reprinted (with permission) from Eggerman and Panter-Brick (2014).

steady employment, and formal education. Young Afghans grow up in environments characterized by violence, poverty, and deep-seated inequalities: they live and breathe a noxious combination of violent conflict, economic stressors, gender discrimination, ethnic divisions, and widening social gaps. In this context, risks to health are multiple and multifaceted, as well as socially produced and perpetuated.

Afghan families, however, have demonstrated a striking fortitude in coping with political, social, and economic adversity that ranges from irksome everyday stressors to traumatic life events. With state governance showing little clarity of purpose, the family has proven the only stable institution available to provide networks of support (Dupree 2004). Families are the primary resource for structuring individual and collective life—and for structuring all instrumental aspects of child development, health, education, social, and economic advancement. In terms of their fortitude in facing adversity, the people of Afghanistan could be held up as a prime example of collective resilience, an everyday resilience embedded in the social contexts of family and community networks.

Some questions remain. How do these general points play out in the lives of actual people? What kinds of evidence do we look for when characterizing health and resilience? From a policy standpoint, what kinds of risks need to be addressed, and what kinds of material, social, and political resources need to advocated?

Interdisciplinary Research

We examined these issues in the context of conducting a study designed to understand adversity, risk, and resilience in the wake of war and displacement (Panter-Brick and Eggerman 2012). We conducted the first systematic, longitudinal, and interdisciplinary study of mental health and resilience in Afghanistan. We interviewed a large sample of 11- to 16-year-olds (1011 youth, both boys and girls), together with their principal caregivers (1011 adults) and school teachers (358), in Kabul, Bamiyan, and Mazar-i-Sharif. We also tracked a small cohort (364 child–adult pairs) in Kabul over a one-year period. Our work examined which aspects of violence and poverty were the most critical predictors of mental health status, and which aspects of individual and social life best characterized the ability to overcome adversity, as expressed by Afghan youth themselves and echoed by family members.

Our large-scale survey was based in schools, which provided the best point of contact to draw a community-level sample, to access both male and female youth, and their male and female caregivers, and provided a safe context for in-depth interviews. The security situation proved very volatile; during 2004, a local non-governmental organization withdrew support for the project because the vehicle transporting the female interviewers had returned after dark; during 2006, our project office was sprayed by gunfire during riots in Kabul; during 2007, suicide bombings in Kabul had become a significant threat. Working with schools made it possible for our field-team (three male and three female Dari/Pashto interviewers, one translator, and a bilingual project manager) to build trust and obtain multiple measures of mental health and social functioning. We wanted a broad picture of Afghan lives, sensitive to age, generation, socioeconomic group, ethnicity, and rural-urban location. Participants engaged well in the research: children told us this was the first time someone had ever asked them about their problems and difficulties, teachers told us this was the first time they had been asked to reflect on how children's psychological health might hamper their educational performance, and our survey provided the first-ever opportunity for some women, from conservative families, secluded at home to visit their children's school.

Mental Health and Everyday Violence

We highlight here two main findings of the study. First, poor mental health (probable psychiatric disorders, depression, and post-traumatic stress) had four main drivers: gender, trauma exposure, caregiver wellbeing, and geographical area. Thus Afghan girls were two-and-a-half times more likely to have ratings indicative of a psychiatric disorder than boys. Children who experienced five or more traumatic events were two-and-a-half times more likely to have psychiatric ratings, and three times more likely to report post-traumatic stress, than those who reported fewer than five events. Child mental health was correlated to caregiver mental health, with the likelihood of psychiatric disorder increasing by 10 percent for each and every symptom of psychological distress reported by their caregiver. Finally, children living in Kabul were more likely to have psychiatric and post-traumatic stress ratings than those in Bamyan or Mazar-i-Sharif.

Those findings signal that poor mental health is a significant issue for the next generation in Afghanistan: overall, one in five (22 percent) school-children in Afghanistan suffered from mental health problems in the clinical range, twice the rate expected for this age-group. However, they also signal that a majority of children managed to function quite well according to ratings given by local respondents. We concluded that one in five Afghan school-children were at risk of a probable mental health disorder, but we also concluded that four in five children proved fairly resilient.

We also reached a largely unexpected conclusion: in Afghan children's lives, 'everyday violence' matters just as much as 'militarized violence' in the recollection of traumatic experiences. We saw that Afghan children were remarkably good at discriminating traumatic from merely stressful life events and that most families were very good at shielding children from traumatic experiences: only 63.5 percent of children reported one or more traumatic events, and only 8.4 percent were exposed to five or more traumas in their lifetime. We also saw that trauma was not confined to acts of war: children identified life-threatening accidents, medical treatments, domestic beatings, and violence in the neighborhood as their most distressing lifetime experience, not just war-related injury, loss of relatives, and forced displacement. It was not just war-related violence that created trauma in the lives of children but violence at the level of family and community life and violence generated by the ongoing exposure to harsh social and economic stressors that spilled into brutality close to home.

Trauma in Context

The following two vignettes illustrate the importance of contextual, subjective, and social experiences in the recollection of traumatic experiences. They focus on why children, exposed to multiple traumatic experiences, would prioritize a single trauma in terms of psychosocial significance.

Our first example is the narrative of a 16-year-old girl, with post-traumatic stress disorder. She described her close relatives as 'martyred' (Dari: *shaheed*). She saw firsthand the beheaded body of her grandfather 'killed in a rocket attack in Kabul during the Taliban' and knew her father had also been killed in a rocket attack. Yet her most distressing lifetime event was a medical operation, to remove a lump in her right breast. She had been taken on a long bus journey to Pakistan, four months earlier, to be operated upon by unknown male surgeons. This happened just at the end of the school year and conflicted with her final-year school exams. She would now have to repeat the entire school year to pass exams, this was particularly frustrating, given her ambition to go on to university and become a medical doctor and also very difficult to negotiate, given social pressures to marry. Her drive to complete her schooling was shaped by a sense of duty toward her parents and her wish to improve her family's financial prospects; her 25-year-old brother was unemployed, living at home, and addicted to opium.

This young girl was clearly wrought by an acute sense of failure and injustice. With respect to the deaths of her father and her grandfather, she could articulate her grief in terms of the ideology of martyrdom, a cultural script of moral and social value. However, she could make no sense of a lost year of schooling, given the anxiety and fear of being taken out of school before she could get her school-leaving certificate, being of marriageable age. In her words, she had lost 'all I had ever worked for'. The relevant question to ask, here, is: 'what really matters' to ordinary people, in normal and extraordinary times, when living a life amidst uncertainty and danger? (Kleinman 2006). Narratives give us the moral dimension of heart-wrenching experiences and prompt us to ask what '*should* really matter' as we 'unearth the huge varieties of cultural meanings' when recounting subjective and social experiences. In this particular case, what mattered was the wider impact of the operation: she bore a physical, an emotional, and a social scar, due to a break in the scaffolding of her life—a post-traumatic stress linked to a rupture of meaning and a rupture of moral order.

The second example is a 14-year-old boy born in Kabul in 1992, when heavy fighting between Mujahedin factions over control of the capital began. He had experienced ten different frightening, violent, and/or distressing events over his lifetime. Seven of his close relatives had been killed in the wars, going back to the Communist period, and one of his brothers had been missing for the last 16 years. His mother had twice attempted suicide and had suffered a miscarriage following a severe beating by his father. In addition, the boy had been knifed in the leg in a neighborhood fight, and he had also had a run-in with the police, who had beaten him and jailed him for a day. Despite all these events, the boy identified his most distressing lifetime trauma as a severe beating by his father six months earlier. He now wished 'to escape from the house' and become a journalist. He was in love with a girl, his cousin, but knew this love would anger his parents if they ever found out. He expressed a desire to leave Afghanistan—to be in a place 'where boys and girls can be together'—and he bluntly described the crux of his misfortune as 'having been born in such a desolate, God-forsaken country'. The boy was severely depressed, his trauma and depression clearly rooted in a fraught family life and macro-level sociocultural stressors.

Mental Health in Conflict Zones

We thus reached a novel insight into child mental health in conflict zones: everyday suffering in the family and community context matters just as much as exposure to war-related violence. Ongoing, everyday stressors—factors other than war-related violence, though linked to the social and economic upheaval of war—account for much of children's psychological distress and mental health problems. This means that we cannot focus attention solely on the most visible forms of violence but need to understand how military, structural, and domestic violence are intertwined. Afghan communities suffer ongoing forms of violence that are not necessarily confined to war: they face *every day and structural violence*, not just militarized violence.

We tested that insight with a follow-up survey, one year after baseline. Due to formidable logistic and security problems, however, we could only follow-up our cohort in Kabul, and even in the capital, we could only trace 64 percent of our participants (other students had left school, and due to the absence of records regarding home addresses, all their families were lost to follow-up; there was no attrition bias with respect to demographic, socioeconomic, or mental health characteristics). Again, we were surprised by two main findings.

First, over a period of a year, child and caregiver mental health had improved, for all measures except post-traumatic stress. This improvement occurred in the absence of a dedicated mental health intervention or even better political and economic security: of the 234 families in our follow-up, 45 moved home, 16 were threatened with eviction, 51 lost a wage-earner, and 178 incurred a substantial debt. Such families were able to anchor their adolescent children in school, despite incurring substantial debt, being afflicted by illness, being anxious about the surrounding violence, and confronting economic and cultural dictates to have adolescent boys earn money and adolescent girls get married. In this context of poverty and insecurity, keeping children in school was an important indicator of fortitude in the face of material and social adversity.

We concluded that:

> In Afghanistan, the ability of families to maintain psychosocial and material resources, and particularly to remain geographically stable, economically robust, and socially supportive enough to keep near-adolescent boys and girls in school for yet another year, may capture an important facet of resilience. (Panter-Brick et al. 2011, p. 360)

Adults and children alike were focusing on school as the gateway to socioeconomic advancement, to alleviate economic stressors, and to maintain family unity. Anchoring children in school was a significant expression of hope and resilience in a high-risk environment.

Second, the quality of family relationships was a key predictor of psychiatric mental health difficulties and depression: domestic violence, traumatic beatings, and family conflict predicted worse outcomes, while family 'harmony and unity' (Dari: *ittifaq and wahdat*)—local terms meaning a sense of family connectedness—predicted better outcomes. This is striking, given the context of extraordinary levels of militarized violence: participants knew of suicide bombings that had resulted in the deaths of children on a school-trip, had witnessed suicide bomb attacks at bus stops/police stations, or witnessed the aftermath of such attacks. We concluded that proximate family environments were more salient than collective violence for their ongoing impact on psychiatric and depressive burden.

This was not the case for post-traumatic stress, which did not abate over the intervening year, and for which lifetime trauma exposure trumped all other risk and protective factors. This suggests distinct pathways of risk and resilience: the quality of family relationships is central to developmental resilience, alleviating psychiatric difficulties and depression, while trauma and post-traumatic stress may be unresponsive, once manifested in the individual child. There is no one pathway of resilience, such as family support, driving all mental health outcomes, just as there is no single driver of poor mental health, such as war-related violence.

Hope and Suffering

Afghan families articulated quite clearly the material, social, and political threats to mental health, as well as the psychosocial and structural dimensions of resilience (Eggerman and Panter-Brick 2010). An everyday struggle for life was first and foremost expressed in terms of its material dimensions: as one father succinctly stated, 'Lack of work is the root of all a man's miseries'. For men, stable work and income was the root of personal dignity; an inability to contribute to their families' livelihoods was equated with a loss of honor and resulting social marginalization. For women, lack of money meant that families had to crowd together in very small residential spaces, or live under tents in communal courtyards, which generated huge stressors, especially given cultural dictates on female seclusion; one woman flatly stated that she would rather go hungry than live without having her own home, meaning that she would not have to co-reside with her husband's extended family. Both adults and children spoke of a 'broken economy' (Dari: *iqtisad kharab*), as the central driver of pain, violence, and misery, and viewed domestic violence as a product of the frustration, strain, and humiliation engendered by material poverty. One 16-year-old girl expressed this as follows:

> My father's salary is not enough for us, he has *takleef asabi* [affliction of the nerves] and he beats us. … If he finds a decent job then maybe he will calm down.

This statement is emblematic of narratives expressing economic drivers as the nexus of social suffering, with suffering engendering family level violence and cascading from one generation to another.

The core reasons for psychosocial suffering were thus structural, regarding overwhelming economic impediments to physical, social, and emotional wellbeing. Another example shows how social aspirations and expectations are crushed by harsh material realities, leading, in extreme cases, to attempted suicide. An 18-year-old boy stated:

> I'm the eldest son in my family. We've got six people in our home, and I am the only one working. … Because we have economic problems, my father forced me to quit school. So I swallowed rat poison after that, and I was in hospital for a week. They pumped my stomach out and I couldn't eat for nine days.

The statement shows how crucial access to education is for the maintenance of hope. The counterpoint to this discourse of suffering was a discourse of fortitude and resilience. Our thematic analyses of interviews with 1011 children and 1011 adults showed that families bring up their children to espouse six fundamental cultural values: religious faith, family unity and harmony, the obligation of service to family and community, perseverance or effort, good morals, and social respectability or honor. These cultural values form the basis for hope and resilience and give families a sense of order and promise in their lives. Resilience was most clearly expressed in this short statement by a 28-year-old mother: ‘Life feeds on hope’. Another expressed this sentiment as follows:

> The only way to make life better is to be hopeful. … If a person has hope, then he or she can work and acquire knowledge to make their life better.

Simply put, Afghans put their faith in the belief that hard work and sustained effort can help them make life better. Their sense of hope is directed toward accessing the resources that will create social and economic opportunities for their family. This is ‘social hope’—the bedrock of resilience.

Indeed, one of the most surprising aspects of this research was the expressions of hope in the midst of everyday suffering. For children, the height of their personal and social ambitions was well demonstrated in the drawings which students produced for this study. As part of rapport-building, before implementing the survey, we asked students to draw themselves in the present and in the future. Most students drew themselves in rags and tears in the present and as excellent doctors, remarkable engineers, and dedicated teachers in the future. We reproduce here two drawings that clearly encapsulated

Fig. 18.1a The present, drawn by 14-year-old girl

hardship in the present, hope for the future, and demonstrate that while Afghan children may live in poverty, they do not show a poverty of aspiration.

The drawings of a 14-year-old girl, who attended a school catering to vulnerable social groups (street-children and war widows), provide a striking example of this hopeful orientation toward the future. She was the only breadwinner in her household, living from rag-picking and finding scrap plastics (see Fig. 18.1a), before and after school, for resale in a junkyard. Her severely depressed mother stated that her greatest worry in life was to see her daughter grow up—because after puberty, she would not be able to send her into the streets to work. What were the girl's aspirations for the future? The girl drew herself at a table, with a microphone, stating that she wanted to be the first female newscaster at radio Kabul (see Fig. 18.1b). Such high hopes, engendered by access to education, might well have been raised here to the point of illusion. Far more elaborate were the drawings of a 14-year-old boy, who attended an art class at his school. He drew his great hardship in the present day (see Fig. 18.2a): he worked, outside school hours, because his father was disabled and his three brothers were 'martyred' in the war. In the future, his ambitions to be a doctor (see Fig. 18.2b) were a world away from his present circumstances: he could picture his car, briefcase, and doctor's office in striking detail. The drawing of his present life is emblematic of misery, while the drawing of his future is emblematic of dignity.

Fig. 18.1b The future, drawn by 14-year-old girl

Fig. 18.2a The present, drawn by 14-year-old boy

Fig. 18.2b The future, drawn by 14-year-old boy

Beyond Superficial Views of Resilience

Despite the protective effect of cultural values that emphasized faith, effort, and family unity, young people also found themselves oppressed by cultural dictates governing their choices and life trajectories. ‘Social hope’ for social and economic improvement could easily lead to social entrapment. On the one hand, Afghan cultural values fostered resilience to everyday adversity. On the other, they caused many Afghans to feel they were falling short of material and social expectations, a threat to their dignity and wellbeing. People suffered great psychological distress when they found themselves unable to conform to the high standards of ‘what makes an honorable Afghan’. Failure or frustration in attaining social and cultural milestones was articulated in local idioms of stress, anxiety, depression, or family conflicts that were debilitating and life threatening. Afghans live in a world where cultural values are necessary for survival, yet also lead to forms of oppression: thus culture is not only the anchor of resilience but also an anvil of pain.

Understanding suffering on a social scale includes the consideration of structural factors that impact peoples’ sense of wellbeing and material lives. In not fulfilling their cultural obligations, such as arranging a good marriage or securing a good job to achieve social and material status, young Afghan men and women become entrapped within a series of cultural standards that they are not always able to live up to. Afghan youth strove to bring themselves out of poverty, to work hard, and obtain a good education, but simultaneously they had to provide service to their family, and leave school to obey cultural directives for girls to marry and boys to provide financial support. They become entrapped within the system of cultural values that define their lives while struggling to cope with political violence, insecurity, and the structural violence engendered by everyday social stressors. Thus owning one's own home and holding down employment is a salient milestone in the context of forced displacement and a broken economy; getting married, begetting children, and providing service to one's family is another, given the importance of family as a social institution; accessing formal education after the forced curtailment in the Taliban regime is yet another precious goal, necessary to achieve economic and social standing in the Afghan context. Education, employment, timing of marriage, and home ownership—these were key to realizing the societal blueprint of social prominence, respectability, and honor (Dari: *'izzat*). For Afghans, these are the economic, social, and moral goals that underpin honor and self-respect.

Such life goals are not intrinsically different from the standard American set of 'goods' and milestones that comprise the normative life course of youth in the USA, the core elements of a 'good enough' life. But in Afghanistan, there are huge impediments to achieving the outward manifestations of an 'honorable life', given economic, social, legal, and political barriers to accessing resources and deep-seated gender and ethnic inequalities structuring resource provision. Furthermore, living an honorable or good enough life is a family matter rather than a personal objective: families are at once the most important sources of social support, and the most important sources of social pressure, in the pursuit of culturally relevant milestones.

Policy Implications

Many forms of violence and suffering arise from structural barriers and social entrapment. If young Afghans are to become more resilient to the challenges they face, we argue that a better understanding of resource provision and social aspirations is needed, both to alleviate suffering and to foster building hope. How young people in Afghanistan cultivate resilience could be greatly assisted by listening to their accounts of their experiences.

Afghans tell us of suffering engendered by ongoing political violence, frustration with the lack of economic momentum, a dearth of service infrastructure, poor governance, and fraught relationships played out at the family and community level. In the Afghan context, a culturally relevant mental health intervention would be a structural intervention to strengthen families and sever the insidious linkages between political insecurity, economic instability, domestic crowding, and domestic violence that threaten wellbeing. These efforts would provide structural, social, and economic resources to families who struggle with everyday stressors. To accomplish this requires efforts to revitalize the economy in order to give dignity to men, providing better housing and reducing overcrowding which would make families feel more secure and alleviate considerable stressors for women; in schools, increasing the quality of education would help children thrive in an environment they greatly value, and in particular, paying teachers a decent wage which would mean they would not be compelled to hold down two jobs.

Policies that address the 'structural' determinants of resilience would enhance a sense of safety, a sense of coherence, a sense of moral order, a sense of hope, and a sense of family connectedness—all of which are essential elements of intervention efforts and principles at the heart of mental health and psychosocial resilience. While specialized psychotherapy is needed for individuals with trauma-related problems such as post-traumatic stress disorder, resource provision is needed to strengthen and revitalize communities, providing psychosocial support to individuals and families whose major problems are not solely the consequence of trauma. What is important is concerted action to address the structural causes that debilitate wellbeing (Panter-Brick et al. 2014).

Finally, our work leads us to emphasize an important ethical issue inherent in intervention efforts to 'build hope' in humanitarian areas. In Afghanistan, a program of massive refugee repatriation promised hope to returnees but largely disappointed their expectations. A massive Back to School campaign was launched in 2001, after the fall of the Taliban regime, to provide hope for children and their families in the form of state-sponsored free education. But searching for hope brings disillusionment in societies where there is a shrinking configuration of social opportunities, widening inequalities, poor distribution of capital, and inequitable state policies. Our data show that hope for the future is central to resilience, but that access to school has raised aspirations to the point of certain disillusionment, as families anchor their children to school despite significant socioeconomic impediments, to achieve the promise of a school-leaving certificate, a good job, and socioeconomic advancement. Paying close attention to resource provision and social processes is important: social policies and intervention programs that build up hope and raise expectations must not promise more than they can deliver.

Conclusion

How does this research speak to the impact of violence on mental health and the cultural values that foster resilience? For general mental health, what matters most is family connectedness, as measured by the local concept of family unity. For resilience, what matters most is a sense of coherence pertaining to cultural and social trajectories, the expression of social hope. Resilience is best understood in terms of trajectory, a sense of meaning-making that orders the world and gives coherence to the past, present, and the future. In conflict zones, we often conceptualize and measure resilience as merely the absence of mental health problems despite exposure to significant trauma. This is a significant shortcoming, focusing as it does on the past as it affects the immediate present—the perspective peculiar to western, trauma-focused psychiatry. By contrast, an emic view of resilience in Afghan societal and cultural contexts is best captured by the expression of 'life feeds on hope'. This places the focus of attention squarely on the future, rather than the past, as it impacts psychosocial wellbeing in the here and now.

Our longitudinal work shows that family environments outweigh war-related violence in predicting children's psychiatric and depressive burden but not post-traumatic stress. And continued attendance at school, per se, was associated with improvements in mental health: expressions of hope attest to the resilience of Afghan families striving to overcome life adversity, and education is, par excellence, an engine of hope in promising the young generation the opportunity of socioeconomic advancement. Thus present-day family relationships and future-oriented hopes for socioeconomic improvements are central to developing resilience. What matters for Afghan wellbeing are cultural values that make sense of day-to-day suffering, underpin a sense of social order, and give a promise to life. These generate, however, problematic tensions regarding social aspirations and likely frustrated expectations, when cultural values themselves become a form of social entrapment. In brief, the 'drip-drip-drip' of everyday socioeconomic stressors is one of the most critical determinants of mental health, even in conflict settings. Such stressors impose a major burden on family relationships, but they are counteracted by remarkable expressions of hope that provide the cornerstone of resilience in Afghanistan.

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19

A Multidimensional Approach to Poverty: Implications for Global Mental Health

Jean-Francois Trani and Parul Bakhshi

Introduction

Poverty and mental disorders[1] have been shown to interact in a cyclical process (Lund et al. 2011). People with mental disorders are often marginalized in low- and middle-income countries (LMICs) and fall through the gaps of international development efforts (De Silva 2015; World Health Organization 2010). Mental disorders represent an increasing contributor to the global burden of diseases; there was a 68% increase in the number of deaths between 1990 and 2010 (Lozano et al. 2012). There is agreement that the unmet needs of hundreds of millions of people with mental disorders should be included in the international community target for the post-Millennium Development Goals agenda (Thornicroft and Patel 2014). The United Nations working group on the new Sustainable Development Goals (SDGs) has indeed included mental health and wellbeing in SDG #3.4.

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[1] In the present chapter, mental disorders refer to mental illness diagnoses, learning or intellectual disability.

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Yet, evidence of a link between poverty and mental disorders is scarce and few studies have investigated the direction of the relationship between mental illness and poverty in LMICs. Research has explored whether poverty increases the risk of mental disorders—the social causation pathway—or whether people with mental disorders are at greater risk to fall into or remain in a state of poverty—the social drift pathway. Studies reflecting a social causation pathway investigate if poverty increases the risk of mental disorders through discrimination and social exclusion, violence, stress and anxiety, malnutrition, poor health status and increased obstetric risks (Das et al. 2007; Khan et al. 2008). According to studies exploring the social drift pathway, increased health expenditure, reduced productivity, stigma, unemployment and low income increase risk of poverty among persons with mental disorders (Perese 2007; Trani et al. 2015). Evidence from systematic reviews conducted by Lund et al. (2011) concluded that, although some asset promotion initiatives demonstrated some potential benefit, poverty alleviation interventions had an inconclusive effect on mental disorders. On the other hand, interventions addressing mental disorders were related to improved economic outcomes in all studies. The review brought to light the variations in definitions of poverty as well as in the methods and tools that were used to assess Common Mental Disorders (CMD). The study also stated that some aspects of poverty (education, food insecurity, social class, socioeconomic status and financial stress) seem to be more strongly related to CMD than other (income, employment and consumption). Going beyond the one-dimensional analyses that seek to establish links between one aspect of poverty and CMD, in this chapter we strongly argue that poverty needs to be reframed within specific contexts as a multidimensional phenomenon. Poverty is not merely defined as lack of income but is also characterized by deprivation of education, healthcare, food intake, shelter, employment, social status, citizenship, physical safety and psychological wellbeing among others. Deprivation thresholds thus can be set with relevance to the population considered. We further argue that in order to better grasp the complex relations between poverty and mental disorders, psychological and social factors (social exclusion and stigma and self-esteem) need to be considered to decipher both the social causation and social drift pathways.

To investigate the link between mental disorders and multidimensional poverty, the authors draw on their research about developing innovative ways of defining and measuring poverty in three different countries (India, Nepal and Afghanistan). This body of research follows the Capability Approach (CA) of Amartya Sen and Martha Nussbaum (Nussbaum 2000; Sen 1985) and aims at demonstrating the need for more contextually sensitive multidimensional measurements of poverty to be employed in Global Mental Health-related initiatives. We offer a unique perspective of measuring poverty based on a choice of dimensions, indicators and weighting schemes that tailor the measurement of poverty to the local context. Most existing studies measure the same indicators across countries, which can serve to facilitate international comparison, but may serve to inhibit a deeper understanding of what dimensions of poverty are of concern to specific social groups in a given context. In the absence of such context-specific measures, mental health interventions are defined broadly and risk excluding some groups of people with mental disorders. Furthermore, it may be that the services that are available are not appropriately adapted to meet the needs of the people in that context.

Approaches to Understanding and Measuring Poverty

Traditionally, poverty is defined through a single indicator of household consumption or income. For instance, the poverty line in Afghanistan is based on the Cost of Basic Needs approach, which assembles a basket of goods and services that are deemed necessary to meet a minimum standard of living (Central Statistics Organization and World Bank 2010). Those falling short of the poverty line are identified as poor. The poverty line consists of (1) the food poverty line and (2) an allowance for basic non-food needs. The food component is defined by the minimum caloric intake (i.e., the number of calories the body requires for a person to function on a daily basis). Aggregating expenditure on goods and services composes the non-food items.

This approach has been criticized by Sen (1976) who argued that it does not take into account the relative situation of the poor: individuals defined as poor remain poor even if they benefit from an increase in income as long as they remain below the poverty line (Sen 1976). Sen's (1976) seminal work aiming at a multidimensional measure of poverty has addressed the issue of identifying the poor and aggregating their characteristics in a unique index. The multidimensional approach draws on Sen's CA and focuses on various factors that impede individual's wellbeing. Sen gives pre-eminence to the individual's wellbeing, which does depend not only on income but also on capabilities, and agency, the individual's freedom to achieve goals the person values (Sen 1999). Poverty defined as deprivation of capabilities refers to the absence of choice for a person to lead a life that he/she values. Multidimensional poverty measurement and analysis enables a greater understanding of how the inclusion of non-income dimensions can modify the appraisal of poverty. Multidimensional measures provide an accurate, easy to comprehend, able to identify variation through time, in depth and yet integrated view of poverty (Bourguignon and Chakravarty 2003). Furthermore, multidimensional measures enable researchers to view not only how many deprivations people experience at the same time but also how these overlap. Development practitioners and scholars use a wide range of definitions of poverty and differ in the breadth and narrowness of the concept and associated measures (Ruggeri Laderchi et al. 2003; Spicker et al. 2007). There is no consensus on a given definition of poverty. Ruggeri Laderchi et al. (2003) have raised several issues that arise with measuring poverty. First they consider the **space** in which poverty is measured: material poverty only or freedom of choice as well, as in the CA. Second, the authors raise the question of the **universality** of the definition of poverty: does the measure of poverty need adaptation to specific sociocultural contexts? Third, the question of the **objectivity of the method** for measuring poverty is raised. The authors argue that value judgements—about the definition of poverty, the choice of the type of measure of poverty and the threshold distinguishing the poor from the non-poor—are made by experts and researchers that all affect the measurement of poverty. We argue here that those choices should involve various stakeholders, including the poor themselves. Fourth, the question of the **threshold** or "poverty line" that discriminates the poor from the non-poor is essential. Fifth, the **unit of definition** is important. Poverty can be considered at the level of the individual or the household, as some resources such as shelter and access to water are common to the household, and sometimes to a whole community (access to a spring or a well for water for instance). The sixth issue is **multidimensionality**. Welfare economists consider that monetary metrics encompass all aspects of poverty. Proponents of Sen's CA consider that poverty has multiple dimensions, which raises the question of measurement of each of them and their aggregation in a single index. Seventh, the **time horizon** considered in poverty measurement has an impact on who is captured as being poor. Depending on the measure of poverty, the importance of the time horizon differs. People can move in and out of poverty in terms of income or be durably poor. In terms of deprivation of capabilities or social exclusion, even deprivation at one point in time (for instance child malnutrition) might have long-term consequences. There are multiple ways in which poverty can be conceptualized, and the present chapter will only explore major ways in which poverty has been defined.

The Monetary or Welfare Approach

The monetary approach (MA) is the most widespread approach to poverty and is based on either household consumption or income. The welfare of an individual is thus reflected by the maximization of utility that is viewed through the lens of expenditure or income: a higher individual level of income or expenditure indicates a higher individual welfare. The monetary approach defines poverty as a welfare shortfall in comparison to a poverty line. This poverty line is defined as a minimum level of material resources (goods) valued at market price (the dollar value of these goods is estimated in the national or local context, for instance the price of food items at the market). The absolute poverty line defines a standard in terms of physiological survival, by reference to minimum nutritional needs or alternatively to a wider range of basic needs (food, housing, water access and clothes). The relative poverty line refers to a bundle of goods and services that are deemed necessary to meet a minimum standard of living defined in a given economic and social context and varies according to the level of development of a country.

The monetary approach presents the advantage of utilizing indicators that are easy to understand and construct. Yet, several criticisms have been formulated. Firstly, the *household* is taken as the unit of analysis for data collection, but welfare and poverty are characterized at the level of the individual as well. Therefore, debatable assumptions are made. One assumption is related to the intra-household distribution of resources: which individuals get what share of the household resources? It has been shown that individuals with disability including mental disorders are at risk of receiving a smaller share of these resources due to prejudice and discrimination they face in the household (Groce et al. 2011). Another assumption is linked to the variation in individuals' needs within the households. Some individuals—for example, teenagers—might need more food than others—for example, elderly people. The allocation of resources often disadvantages some members of the household such as women, girls, elderly and persons with disabilities. In particular, people with disability including mental disorders might need more resources to reach the same level of wellbeing than other members of the household because of their condition (Sen 1995) (Erb and Harris-White 2001). Finally, assumptions are made about the possible marginal gain made: for instance, a large household will spend relatively less money per capita than a smaller household because it will buy larger quantity of food at a lower cost. Household information may result in underestimating inequality and poverty (Haddad and Kanbur 1990). Second, the use of nutritionally based poverty lines is disputed, as studies have found that the incidence of poverty obtained using this line of enquiry is incompatible with the reported prevalence of malnutrition, and adequate nutrition varies according to age, gender, activity and biological differences (Ray and Lancaster 2005). Third, an income above the poverty line does not necessarily equate to a good quality of life. Last, policymakers in LMICs might be inclined to focus limited resources to address the needs of those closest to the poverty line to show effectiveness, as it might be easiest to demonstrate an effect with this group. However, this may inadvertently serve to widen inequality, particularly for the most vulnerable groups such as persons with mental disorders.

Social Exclusion

Social exclusion (SE) as a concept was developed through work conducted in high-income countries such as the work of Lenoir (1974) who looked at those left at the margin of the French society such as individuals with disability, abused children, delinquents, single parents and substance abusers among others. SE in the French Republic context has been understood as a failure of the State to maintain the "cohesion of the society" (Bhalla and Lapeyre 1997). Burchardt, Le Grand and Piachaud (1999) provided a definition of exclusion in the context of the United Kingdom to describe individuals living in a society without participating in the usual activities of citizens in that society (p. 229). Poverty can be understood as a process of exclusion for social and economic activities (Sen 2000). Its central value resides in the analysis of the processes and dynamics that allow deprivations to arise and persist (Rodgers et al. 1995). Atkinson and Hills (1998) define SE through three major characteristics: its relativity to a certain social context, the role of agency as someone is excluded because of the action of one or several agents and its dynamics as the current situation results in future prospects of deprivation. Room (1999) considers that SE relates to a multidimensional, relational (i.e., inadequate social participation and lack of social ties) and dynamic disadvantage in a local context which lacks facilities such as public transportation service, and results in what he calls "a catastrophic discontinuity in relationships with the rest of society" (p. 171).

Research on facets of SE and its measurement have expended considerably in the developed world since the foundational work of Lenoir (1974) (Evans-Lacko et al. 2014; Kolin 2008; Santana 2002). SE has been an important part of the European Union policy since the 1980s. Yet, the SE paradigm has been criticized in LMICs as being of little value in societies where deprivation and political exclusion is widespread. For instance, considering people as socially excluded of a social security system would encompasses the majority of the population (Saith and Queen Elizabeth House 2001). In LMICs, social security systems do not generally exist and support for vulnerable individuals tends to be provided by family and community solidarity and networks. Yet, in the case of persons with mental illness, SE is a major challenge. Indeed, "develop(ing) culturally informed methods to eliminate the stigma, discrimination and social exclusion of patients and families across cultural settings" as been designated as the second most important challenge among the 40 Grand Challenges in Global Mental Health initiative in the next ten years (Collins et al. 2011).

The Participatory Approach (PA)

The participatory approach (PA) introduced with participatory rural appraisal and participatory action research (Chambers 1994) has taken momentum with the World Bank study at the beginning of the millennium that asked the poor in 47 countries what it meant to be poor (Narayan et al. 2000). The PA acknowledges the expertise of people who directly experience poverty as it avoids externally imposed views and conceptions. By giving a voice to the poor, it is argued that this approach provides vulnerable populations with an opportunity to defend their interests. The PA can additionally aid the construction of a list of basic capabilities and prioritize these needs, which is useful for policymakers (Saith 2001). However, the PA has been criticized due to adaptive preferences (Sen 1999; Teschl and Comim 2005). People adjust to adverse and unfair circumstances and do not question the order of things (Nussbaum 2000). This translates in high level of self-perception of wellbeing. There are also concerns that the PA may still exclude the poorest whose voices may remain unheard (Laderchi 2007).

The Capability Approach (CA)

Sen, Nussbaum and followers define poverty in terms of deprivation of capabilities (Nussbaum 2000; Sen 1982, 1985, 1993). Capabilities reflect a person's ability to achieve valued *functionings* (i.e., what an individual can do or be in a given context). Individuals' agency, or freedom, to choose between different ways of performing valued functionings is central to the CA. In the CA, poverty is defined as the "failure of basic capabilities to reach certain minimally acceptable levels" (Sen 1999, p. 109). The CA allows for an analysis of a wide range of issues including economic, social and cultural issues. It takes into account heterogeneity among populations, and it involves participatory processes. Furthermore, it looks at the particular ends that people value, the freedom to achieve those ends and moves the attention away from a narrow focus on the means to the ends (Sen 1999, p. 90). However, capabilities can be hypothetical and question marks remain about whether it is possible to measure what individuals' have the potential to be.

In the field of development, the United Nations Development Program has taken the lead for the adoption of a multidimensional poverty index approach inspired by the CA in its annual Human Development Report since 2010 (Alkire and Santos 2010). The MPI has been introduced building on the Human Development Index (HDI) that measures national average achievement in life expectancy, income and educational achievement. The HDI has been criticized for insufficiently reflecting the level of development of a country and failing to capture several dimensions of quality of life (Sen 2004; Fukuda-Parr and Shiva Kumar 2003).

Alkire and Foster (2011) have proposed a new multidimensional poverty measure, which incorporates Sen's view of poverty as capability deprivation. The measure is flexible, as it requires the researcher to make crucial decisions that involve the selection of dimensions, indicators, cut-offs and dimensional weights, which indicate the relative importance of each dimension. It has also the advantage of allowing the identification of the poorest of the poor by exploring various domains in which poor people are disadvantaged. Particularly, data can be decomposed to uncover which are the domains contributing most to poverty. Furthermore, the property of decomposition allows data to be broken down by subgroups to identify who are particularly deprived among the poor, allowing better targeting and prioritizing individuals who are most in need of support. Overcoming the limitations of the headcount index, the Alkire-Foster measure explores the depth, breadth and intensity of deprivations experienced. Identifying individuals who are (1) deprived on multiple dimensions and (2) experiencing a higher intensity of poverty is invaluable for policymakers in LMICs, as this will allow them to allocate more effectively scarce financial and human resources and prioritize social protection interventions accordingly.

In the present chapter, we report on an attempt to measure a series of basic capabilities and their related functionings. Our work in Afghanistan, India and Nepal led to the development of a contextually sensitive way of conceptualizing poverty in those contexts. We identified 7 dimensions of poverty characterized by 13 indicators of deprivation based on discussion with experts in Afghanistan (Table 19.1). We then tested the relevance of these dimensions through focus group discussions with Afghans. Similarly, we selected 6 dimensions of poverty and 17 indicators of deprivation reflecting aspects of wellbeing (Table 19.2) identified by extensive literature review and validated

Table 19.1 Dimensions of poverty, indicators of deprivation, questions and cut-off in Afghanistan

Dimensions	Indicators	Questions	Cut-off
Health	Access to healthcare	How long does it take to get to the closest available health care facility?	More than 30 minutes
	Food security	How often does your household get enough to eat? (always enough; sometimes not enough; frequently not enough; always not enough; always enough but with poor quality)	Frequently not enough Always not enough
Education	Education	What kind of education did you receive or are you receiving?	No education
Employment	Non-employment	Do you have any income-generating activities inside the house? Do you currently have work (regular or irregular)? Did you work or have a job for at least one hour per day during the last week? Did you work or have a job for at least one day during the month?	No to all questions
Household level Material wellbeing	Assets ownership	Does any member of your household own any of the following? (Radio, tape recorder; Television; Pressure cooker; Oven, hotplate; Refrigerator; Bukhari; Bicycle; Motorbike; Car; Tractor; Generator; Kerosene lamp; Sewing machine; House or apartment)	Less than six assets If family own a tractor or a car they are automatically set as non-deprived
	Crowding space	How many people per room are there in your household?	More than three people per room
	Source of drinking water	What are the main sources of drinking water for your household? (piped into residence/compound/plot; public tap/tap in the neighbourhood ground water; hand pump in residence/compound/plot; public hand pump; well in residence/compound/plot; covered well; open well and kariz; spring; river/stream; pond lake; still water; dam; rain water; tanker/truck)	Well in residence/compound/plot Covered well Open well and kariz Spring River/stream Pond/lake Still water Rain water Tanker/truck

(*continued*)

Table 19.1 (continued)

Dimensions	Indicators	Questions	Cut-off
	Type of sanitation	What kind of toilet facility does your household have? (private flush inside, private flush outside, shared flush, traditional pit, open backed, open defecation field outside the house)	Open back Open defecation field outside house
	Indoor air quality	What is mainly used in your household for cooking? (Gas, stove with kerosene/petrol, firewood, dung, charcoal, electricity)	Charcoal, dung, firewood
Social participation	Social participation	Did you take part in any ceremony during the past years?	No
Subjective wellbeing	Self perception	Choose three adjectives from a list of ten. Different lists for male and female. **Males** Disappointed; Normal**;** Happy**;** Useless**;** Brave; Willing; Proud**;** Oppressed**;** Poor; Deprived **Females** Tactful; Independent; Poor**;** Normal; Distrusting**;** Unworthy**;** Hopeful**;** Excluded; Strong; Weak	Rather negative Very negative (when 1 to 3 negative adjectives selected).
	Mental distress and anxiety	Mental distress is identified by a list of 22-items tool, which takes into account Afghan culture and beliefs. The 22 items incorporate four conceptual dimensions of mental distress: social interaction difficulties, learning difficulties, behavioural disorders and anxiety and depression.	Severe distress (if the respondent gave an answer “yes” to more than 11 items).
Physical safety	Mistreatment	**Male** Has anyone ever ill-treated you? **Female** Has anyone ill-treated you in the house? Has anyone ill-treated you outside in the street or the bazaar?	Yes

Table 19.2 Dimensions, indicators and cut-off of deprivation in New Delhi, India

Dimensions	Indicators	Questions	Cut-off
Health	Health access	Could you receive healthcare when sick?	Deprived of healthcare
	Food security	How many meals are usually served in your household in a day?	1 or 2 meals
Education	Education attainment	What is your level of education?	Primary education completed
Employment	Non-employment	What is your usual primary activity?	Not working
Household level Material wellbeing	Assets ownership	Do you possess any of the following? Mobile phone, landline, wooden/steel sleeping cot, mattress, table, clock/watch, charpoy, refrigerator, radio/transistor, electric fan, television, bicycle, computer, moped/scooter/motorcycle, car	Lowest two asset quintiles
	Crowding space	How many people live in the dwelling?	Less than 50 sq feet per person
	Source of drinking water	What is the primary source of drinking water?	Pipe outside home/public pump/tanker/truck/cart with small tank/water from a covered well/unprotected well/spring/river/dam/lake/pond/stream
	Type of sanitation	What type of toilet facilities do you use when at home?	Open field, pit latrine, improved ventilated pit, public latrine
	Indoor air quality	What is the primary source of cooking fuel?	Wood, coal/charcoal, dung, kerosene, straw/shrubs/grass/crop
	Type of lighting	What is your primary source of lighting?	Generator, kerosene lamp, petromax, candle, none
	Individual income	What is your income?	Less than $1.25 per day
	Housing ownership	Does the family own the house	Do not own the house
	Housing quality	Are the material used for walls, floor and roof in your house kutcha or pucca?	Any of walls, floor or roof is kutcha
	Household per capita income	What is the family income?	Less than $1.25 per capita per day
	Household expenditures	What is the household's monthly expenditure?	Less than $1.25 per capita per day
Physical safety	Safe environment	How safe is the place where you live?	Rather or very unsafe
Political participation	Vote	Did you vote in the last municipal election?	Did not vote

through focus group discussions (FGDs) with experts and PSMI/caregivers at Dr Ram Manohar Lohia (RML) Hospital, New Delhi, India. Both groups identified and came to a consensus about the deprivation cut-off for each indicator, ensuring that the dimensions were selected through participatory deliberation (Sen 2004). Some dimensions used in the literature on multidimensional poverty were not included due to lack of relevance in the context of Delhi. For instance, a small proportion of respondents did not have access to diet staples.[2] Finally, we identified 4 dimensions of poverty and 11 indicators of deprivation in Nepal using similar methodology (Table 19.3). Several of these dimensions are the same in the three countries: health, education, employment and household-level material wellbeing. Unfortunately, some important dimensions of individual wellbeing such as social or political participation and subjective wellbeing or physical safety, which are often forgotten in surveys (Alkire 2007), have been measured in Afghanistan and India but not in Nepal.[3] We argue that within the capability framework, deprivation of subjective wellbeing is a significant barrier to individual flourishing: people deprived of subjective wellbeing are often unable to accomplish various functionings, as well as social roles and other psychosocial individual capabilities (Samman 2007; Shams 2014).

To be considered multidimensionally poor, an aggregate cut-off point is required. This cut-off point (k) serves as the poverty line. The union and intersection identification methods are commonly used by researchers (Bourguignon and Chakravarty 2003) although are of little use to policymakers. The union method considers a person multidimensionally poor if he/she is deprived on at least one dimension. Following this approach, all individuals in our samples across the three countries would be considered multidimensionally poor. On the other hand, the intersection approach considers a person multidimensionally poor if he/she is deprived in all dimensions. In the three countries, no individuals were found to be deprived in all dimensions. In order to aid policymakers to identify and target the poor more effectively, the use of a cut-off point lying between these two extremes would be more appropriate (Alkire and Foster 2011). It is important to note that the choice of cut-off would depend on the aim of the exercise (Tsui 2002). Our research noted a high impact of poverty found among persons with mental disorders. To be able to intervene in context of limited available resources,

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[2] For vegan individuals, the diet staple included at least dal on a daily basis; for non-vegan individuals, it included dairy products on a daily basis. Meat for non-vegetarian individuals was not considered as a diet requirement, and therefore deprivation of meat is not an indicator of poor diet.

[3] Unfortunately, the authors were not associated with the baseline data collection of the Nepal project and were therefore not able to include questions related to.

Table 19.3 Dimensions of deprivation in Nepal

Dimension	Indicators	Questions	Deprived if…
Health	Late access to antenatal care	How many months pregnant where you when you went for checkup?	Sought antenatal care at more than 6 months pregnant
	Number of access to antenatal care	How many times did you go for checkup?	One visit or less
	Food security	How many months of year does the main occupation support enough food? What do you do to cope with the rest of the months?	Less than 12 months
Education		What is the highest grade did you study?	No education
Employment	Type of employment	Is there any activity in the household besides farming?	No activity besides farming
Household level Material wellbeing	Assets ownership	Which things do you have in your house? Electricity, radio, television, bicycle, telephone	Deprived if belong to poorest 40%
	Crowding space	How many people live in the house	More than three people per room
	Source of drinking water	What is the principal source of drinking water?	Not piped water.
	Type of sanitation	What is the principal type of toilet facility used by members of your household?	Pan, bush, pit or other toilet.
	Indoor air quality	What kind of fuel does your household mainly use for cooking?	Dung, firewood or coal.
	Quality of housing	Is this house your own? How many people live in your house?	More than three per room Does not own house
	Land ownership	Do you have your own land?	Does not own land

policymakers will need to decide where they want to establish the poverty cut-off to decide who to prioritize. If the choice of *k* is set to a low value, poverty would be very high and represent a large group of persons with mental disorders. Consequently, to facilitate a focus on the poorest of poor, a cut-off needs to be carefully selected in a given context. In the remaining of the chapter, deprivation is used for indicators whereas poverty is used with dimensions.

Study Design and Settings

In Afghanistan and in Nepal, mental disorders were identified using locally validated screening tools. In Afghanistan, the screening tool consisting of 27 questions to detect the presence of persons with disabilities within the household was developed based on the International Classification of Functioning, Disability and Health (ICF) (WHO 2001), the Hopkins Symptom Checklist-25 (HSCL-25), the Self-Reporting Questionnaire (SRQ-20) and on the CA (Sen 1995; Sen 1999). The questionnaire was assessed for internal consistency (Cronbach's $\alpha = 0.85$). We tested for reliability and obtained relatively good Cohen's kappa statistic for the whole questionnaire (0.9).

In Nepal, disability was defined as: being disabled through interaction between their impairment and surrounding attitudinal and environmental barriers (UN 2006). We adapted the questionnaire used in the National Disability Survey in Afghanistan (Trani and Bakhshi 2008). This newly developed screening tool had 34 items (DSQ34) (that were scored on a four-point Likert scale ranging from 1–4 with increasing activity limitation) that assessed deficits including physical, sensory, learning, behavioural, neurological and psychological disabilities based on the (ICF) (WHO 2001) and the CA (Sen 1999). The questionnaire captured severity of disability by asking respondents to rank their abilities on a four-point scale.

The DSQ-34 provided both a raw total score for disability and specific scores for each of the six domains. Scores for each domain are divided respectfully into Mobility/Physical (22), Sensory (20), Intellectual/Developmental Delay (28), Behavioural Patterns (40), Mood/Emotions (20) and Neurological (12) (maximum total score = 142). The raw total score was transformed into a scaled total score from 0–100. Respondents who answered "no" to all 34 questions in the disability screen were judged as "non-disabled". Respondents who responded "yes sometimes" to one or two items were grouped as having a "mild" level of disability (minimum score of 34). Respondents were identified as being "moderately" disabled when they reported having at least "sometimes" to three items (score = 38). They were identified as being severely disabled when they reported "Yes, often" difficulties to one to two items (37 =< score =< 39). Finally, they would qualify as very severely disabled if they reported "constantly, always" to one item (score = 38), "often" to three items or more (score >= 41) or "yes" to question five (score = 36). For the purposes of the present chapter, we are focusing on individuals who were classified as either severely or very severely disabled. In Afghanistan, people who are either mentally disabled or who have a learning disability, as well as those having a physical or sensory disability associated with a mental or learning disability, are clustered together for the analysis of multidimensional poverty.

In India, patients with mental illness were recruited at Dr Ram Manohar Lohia hospital, Delhi. Between November 2, 2011 and June 20, 2012, we interviewed 647 persons with severe mental illness (PSMI), informed about the survey by one of the ten treating psychiatrists of the Department of Psychiatry of the Dr RML hospital. Patients who met ICD-10 criteria for schizophrenia or severe affective disorders were consented to participate and subsequently interviewed. We used a control group ("controls" in the remainder) of 647 with no history of mental illness who were matched to the patients according to gender, age (plus or minus 3 years) and by neighbourhood of residency. From the front door of the case's house, we randomly select a direction by spinning a pointer, and we interviewed a matching control in the closest household (nearest front door method) in that direction. Transportation costs as well as a meal were provided to patients to maximize recruitment and reduce selection bias. Investigators together with the team manager contributed to sensitization and awareness raising in the various neighbourhoods of interest to maximize controls.

Results

Higher Rate of Deprivation Among People with Mental Disorders

Figures 19.1, 19.2 and 19.3 report deprivation rates by dimension of deprivation respectively in Afghanistan, India and Nepal. Results show higher rate of deprivation for persons with mental disorders, relative to the other categories, in 7 dimensions out of 13 in Afghanistan. We found higher rates (as indicated by larger bars on the bar-graphs) of deprivation for persons with mental disorders in 13 dimensions out of 17 in India. Yet the differences in levels of deprivation are not observed in the same dimensions. In Afghanistan, levels of deprivation are higher for persons with mental and associated disability in terms of physical safety, psychological wellbeing, employment and social participation compared to levels of deprivation for persons with other types of disabilities and non-disabled people. Levels of deprivation are smaller in terms of material wealth and education. The gap in level of deprivation between persons with mental disorders and the rest of the population is particularly significant for employment in India, and this is largely explained by the stigma

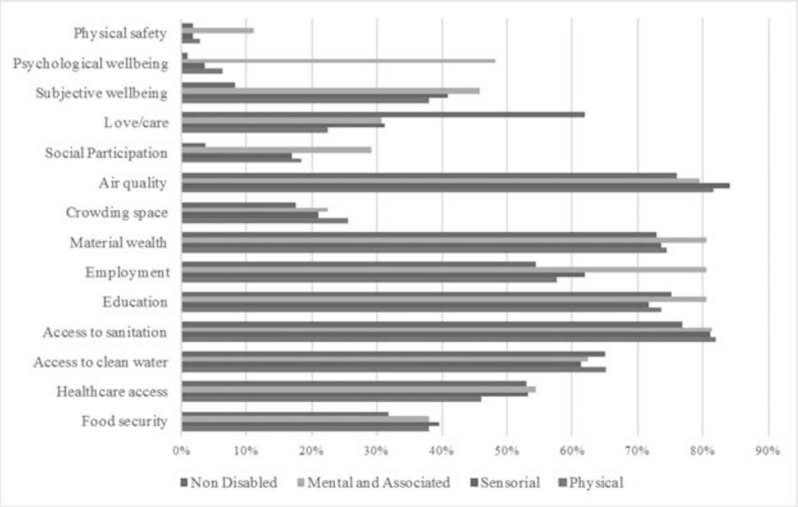

Fig. 19.1 Deprivation rates by indicator and by disability status in Afghanistan

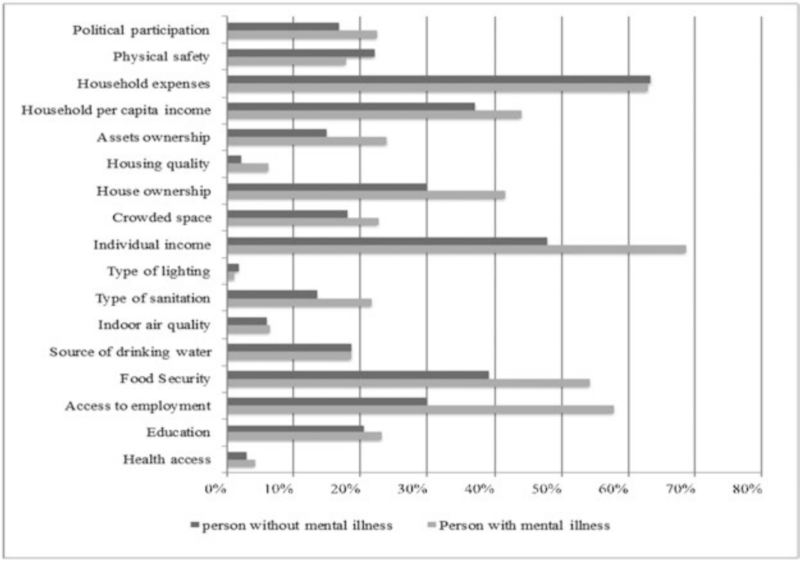

Fig. 19.2 Deprivation rates by indicator comparing persons with and without mental disabilities in New Delhi, India

the former face that excludes them from the labour market (Trani et al. 2015). Literature has shown that in other contexts, including high-income countries, there is a widespread societal belief that persons with mental disorders cannot work or are less productive (Baldwin and Marcus 2006; Corrigan et al. 2006;

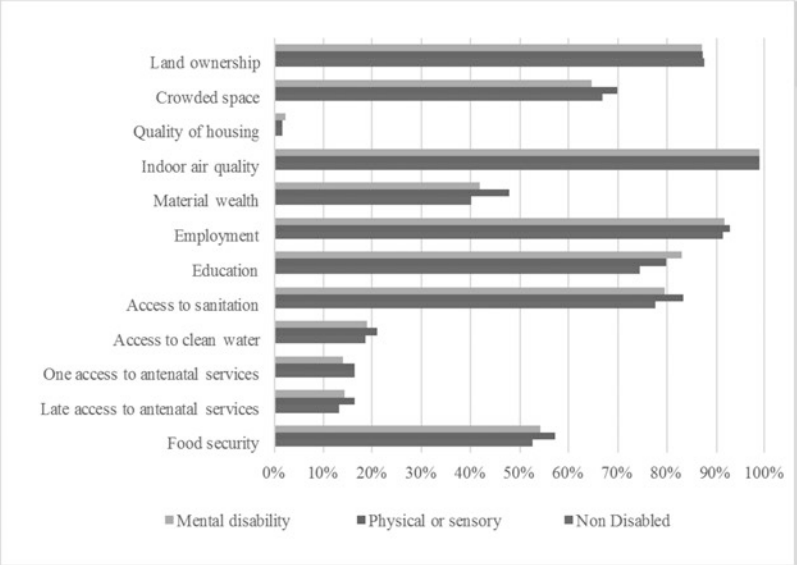

Fig. 19.3 Deprivation rates by indicator and by disability status in Nepal

Gulinelli et al. 2005). This gap in level of deprivation between both groups is also high for food security, individual income and asset ownership in India. Contrarily to Afghanistan, physical safety is not a major issue for persons with mental illness. In Nepal, there was little difference in levels of deprivation according to disability status and type of disability among women.

Higher Multidimensional Poverty Among Persons with Mental Disorders

Figures 19.4, 19.5 and 19.6 compare the adjusted headcount ratio (*M0*) for disability status in Afghanistan, India and Nepal respectively and for different cut-offs across dimensions (k = 1–13 in Afghanistan, k = 1–17 in India and k = 1–12 in Nepal). Very few people are deprived in the highest number of dimensions. Findings show that when the cut-off k increases, the breadth of poverty indicated by (*M0*) decreases. Intensity of poverty is particularly high on a small number of indicators and reduces when a larger number of indicators are considered.

Findings also show that all individuals are deprived on at least one dimension in Nepal, more than 95% of all individuals in Afghanistan and more than 90% in India. As indicated by Fig. 19.4, individuals with mental disorders are multidimensionally poorer on a higher number of dimensions in

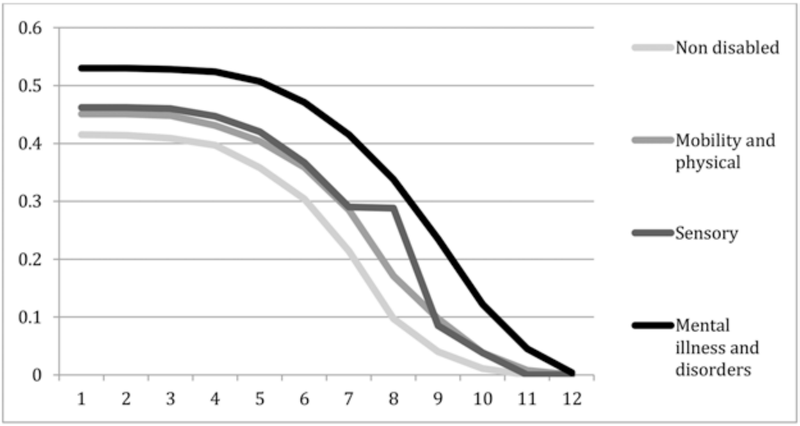

Fig. 19.4 Adjusted headcount ratio (y-axis) for different cut-off *k* (x-axis) of poverty comparing Afghans with mental illness and associated disabilities to other forms of disabilities and to non-disabled people

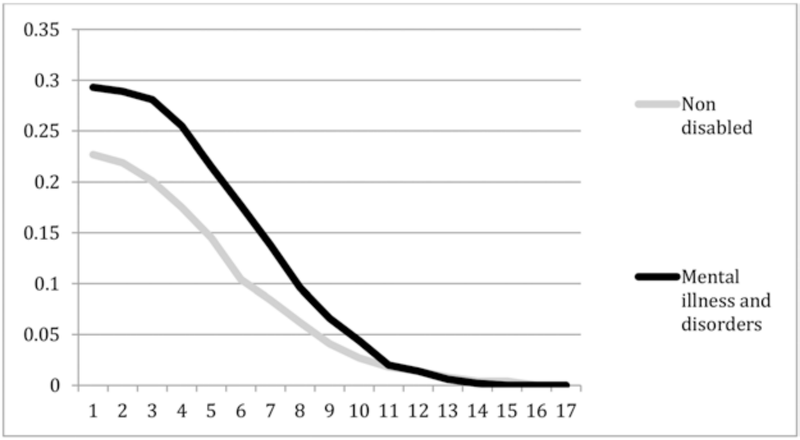

Fig. 19.5 Adjusted headcount ratio (y-axis) for different cut-off *k* (x-axis) of poverty comparing Indian with mental illness to a control group of non-mentally ill individuals

Afghanistan, whatever the cut-off (k) considered. In India and Nepal, it is only the case for (k = 1–6). Results show that people with mental disorders experienced a higher level and intensity of poverty in comparison to non-disabled people or even of people with another type of disability, regardless of the chosen cut-off in Afghanistan and for most of them in India and Nepal where the intensity of poverty becomes similar between the different groups for high levels of cut-offs.

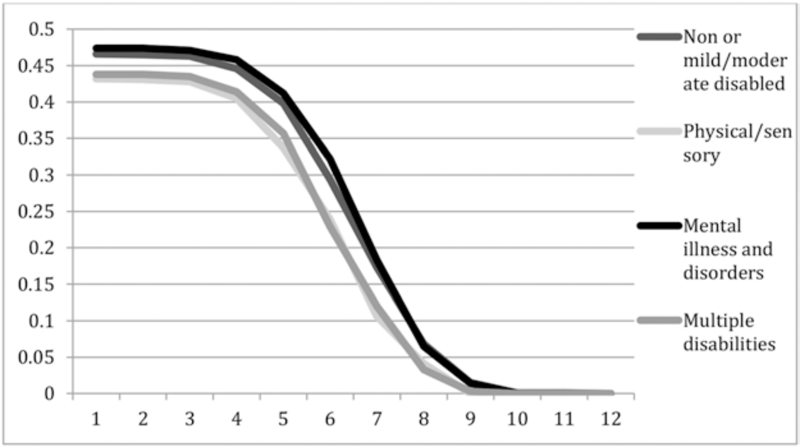

Fig. 19.6 Adjusted headcount ratio (y-axis) for different cut-off *k* (x-axis) of poverty comparing Nepalese women with mental disabilities to other forms of disabilities and to non-disabled women

Concluding Remarks

In the present chapter, we adopted a definition of poverty as deprivation in various dimensions of wellbeing, based on the CA. We argue with others that this perspective, that explores various dimensions of poverty, provides insights that can improve public policy that can be implemented by a large variety of development actors and institutions involved in improving wellbeing of poor and vulnerable populations in LMICs (Chiappero-Martinetti and Moroni 2007).

Our findings demonstrate a strong association between mental disorders and multidimensional poverty in the case of three different Asian countries: Afghanistan, India and Nepal. People with mental disability in LMICs face higher levels and intensity of multidimensional poverty than the rest of the population, including people with other types of disabilities. This is in line with an emerging literature that shows a link between mental disorders and poverty in various LMICs such as China (Li et al. 2012), Ghana (Boyce et al. 2009), India (Trani et al. 2015) and Indonesia (Tampubolon and Hanandita 2014). Many studies use household income or expenditure to measure poverty. Yet, we found that the gap observed between persons with mental disorders and those who do not show signs of these is not only for material deprivation but also in other domains such as health status, education, employment, social participation, psychological or subjective wellbeing as well as physical safety. Significance of various domains of poverty for the wellbeing of persons with mental disability echoes the CA that suggests that being able to engage in valued functionings—such as being in good health, being educated, having a flourishing social life—is important to the individual wellbeing (Sen 1993). Such domains of poverty are also in line with some conclusions made by the recent review of the literature that demonstrated stronger and more consistent associations between measures of poverty such as education, food insecurity, housing, social class, socioeconomic status and financial stress and common mental disorders (Lund et al. 2010). However, the Lund et al. (2010) review also showed a lack of framework within which to appraise relationships between the various measures of poverty within specific social, political and cultural contexts. There is evidently more research required to explore the complexity of poverty through a multidimensional approach.

From the perspective of the CA, income or primary goods and resources are important to provide opportunities for the individual to convert these goods and resources into the fulfilment of what the individual values to do and to be (Sen 1995). Hence, poverty is not only deprivation of income but reflects also various aspects of a poor quality of life, particularly for persons with disability, including mental disability (Graham et al. 2013). Sen argued that persons with disabilities face a "double handicap" (Sen 2009; Sen 1992). In addition to the impact of the mental health disorders, people also face the "earning handicap" that is, a lower capacity to earn an income because of exclusion from employment. In fact, our findings from India demonstrate that a major contributor to multidimensional poverty is unemployment, which is particularly high in the context of the current economic difficulties (Trani et al. 2015). Unemployment is widespread but the situation is worse for persons with disability, particularly those with mental disorders and women. In contexts of high unemployment, promoting employment of persons with mental disorders represents an immense challenge for policymakers. Sen (1992, 2009) also refers to a "conversion handicap" linked to the extra costs incurred by disability. To achieve a certain level of wellbeing, persons with disabilities require more resources than non-disabled people (Braithwaite and Mont 2009). As a result, poverty on various dimensions has an exponential impact in reducing quality of life of persons with mental disorders.

The relationship between poverty and mental disorders is therefore complex and has several implications for policy development relevant to Global Mental Health. Programmes aimed at fighting poverty should prioritize persons with mental disorders who are facing higher levels as well as deeper intensity of poverty than the rest of the population. As a consequence, international development interventions need a nuanced perspective in order to efficiently and adequately take into consideration the needs of persons with mental disorders as a development priority. Such a perspective would include not only creation of opportunities for persons with mental disorders but also efforts to change the prevalent beliefs that sustain stigma and exclusion.

First, in light of the fact that people with mental disorders face multifaceted poverty (Funk et al. 2012), poverty alleviation interventions must be multipronged and cannot focus only on income support through cash transfer, small loans or asset promotion (Ozer et al. 2011; Ssewamala et al. 2009). Lack of income is definitely a concern but deprivation is also prevalent in other domains. Public policies and programmes must address poverty in all its forms. There is a growing body of research showing the negative impact of inadequate housing, poor water and sanitation conditions, lack of provision of adequate healthcare and rehabilitation services (Anonymous 2002; Happell et al. 2012; WHO World Mental Health Survey Consortium 2004), of access to education (Poreddi et al. 2015) and to employment (Mueser et al. 2014) or low social participation on the overall wellbeing of persons with mental disorders. This in turn required coordination and coherence of efforts through various domains, which remains a major challenge in countries where policies are still viewed in separate silos through specific ministries.

Second, promoting rights of persons with mental disorders requires public intervention to address negative beliefs. We argue here that stigma and discrimination of mental disorders is a major impediment to any progress in alleviation of multidimensional poverty (Semrau et al. 2015). Persons with mental disorders experience prejudice, discrimination and exclusion, creating barriers to accessing existing resources and services (Bitanihirwe 2014; Brohan and Thornicroft 2010; Sharac et al. 2010). Stigma is for instance largely responsible for exclusion from the labour market (Baldwin and Marcus 2006; Thornicroft et al. 2009) and exclusion from school for children with mental illness even more than for children with other type of disability (Trani et al. 2012). Public stigma—defined by Corrigan and Watson as the way used by members of the public to stigmatize individuals with mental disorders (Corrigan and Watson 2002)—can also be responsible for deprivation of subjective wellbeing through self-stigma which produces shame and diminishes self-esteem, which constitutes a fundamental aspect of poverty (Corrigan 1998). People with mental disorders are particularly distressed by adverse circumstances associated with phenomenon of discrimination and marginalization which in turn negatively impacts their wellbeing (Ambikile and Outwater 2012). Over the course of the chapter, we have highlighted how within the CA framework, deprivation of subjective wellbeing can be understood as a central independent impediment to individual flourishing: people deprived of subjective wellbeing are often unable to fulfil various functionings, as well as social roles and other psychosocial individual capabilities (Samman 2007; Trani et al. 2011). In our research, we have focused on questions of participation and exclusion from family decisions and community gatherings. More research is needed to explore the link between discrimination linked to stigma of mental disorders resulting in multidimensional poverty including negative subjective wellbeing of persons with mental disability in LMICs (Lund 2014).

Third, poverty also affects the family beyond the individual with mental disorders. Some resources can be directed to the specific needs of the person with mental disorders, particularly medical needs. Furthermore, family members might need to provide care for the person with mental disorders. Finally, the person with mental disorders is unemployed, reducing the potential income of the household. Policy and programmes that contribute to address stigma of persons with mental disorders in the work place are bound to have an impact beyond the person by improving the wellbeing of the overall family. In other words, the collective capabilities of the family can be enhanced by intervention aimed at improving social inclusion of persons with mental disorders. To improve those collective capabilities, organization of persons with disabilities (often led by family members in the case of mental disorders) must lobby for the rights of individuals with mental disorders through collective action (Dubois et al. 2008; Dubois and Trani 2009; Ibrahim 2006).

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20

Balancing the Local and the Global: Commentary on 'Globalizing Mental Health: Challenges and New Visions' Section

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The nine chapters in Part II of this volume provide a rich insight into the challenges facing the practice of mental health in diverse global settings. A major strength of the part is the multidisciplinary perspective that the authors bring, and their willingness to engage with the complexities of this diverse and growing field of research and practice. The purpose of this commentary is to summarize the content of the chapters in the part, to draw out common ground as well as distinctions between the chapters and to provide some critical reflections on the content.

Summary of Chapters

Mills and White pose a number of critical questions regarding efforts to scale up mental health services in low- and middle-income countries (LMICs). These include questions regarding whether the validity of psychiatric diagnosis is being over-emphasized, whether a preoccupation with eliminating symptoms obscures what may be 'positive outcomes' for people who experience mental health difficulties, whether the treatment gap is as large as it is reported to be, whether alternative forms of treatment are being neglected, whether social determinants of mental health are being adequately considered

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and whether the evidence base for Global Mental Health (GMH) is sufficiently supported, particularly in relation to task shifting. The authors cite a variety of studies and opinions to present a robust criticism of current GMH efforts, arguing that such efforts assume a uni-directional flow of expertise (from high-income countries to LMICs) that does not pay adequate attention to alternative and indigenous knowledge and healing systems.

Burgess and Mathias present a conceptual framework for 'community mental health competency' to guide community engagement in GMH practice. Drawing on case studies from settings in India and South Africa, the authors begin by critically engaging with the notion of community and how it is defined in structural and symbolic terms. In the context of fluid and plural notions of community, the authors emphasize the need for caution and an awareness of power and social forces when engaging in community mental health interventions. Furthermore, they criticize WHO and Movement for Global Mental Health (MGMH) discourses of community for focusing on the pragmatics of biopsychosocial service delivery, rather than addressing wider social environments that contribute significantly to mental distress. To address this oversight, the authors propose a 'community mental health competency' framework, for engaging with and promoting community mental health. This framework includes four principles: knowledge; recognition of individual and group-based skills, and solidarity to tackle the issue; safe social spaces and dialogue; and partnerships for action. This framework is illustrated in two case studies: engaging with traditional healers in a rural community mental health setting in South Africa and partnership in a community mental health program in Uttar Pradesh, India. The authors call for a transfer of power about definitions of mental illness from high-income countries to the hands of local communities.

Watters presents three specific challenges to the 'life-course' approach advocated by the MGMH. The first is that the life-course approach represents a form of 'epistemic violence' in which the diagnostic systems of western psychiatry, with its notions of mental health literacy, are imposed on indigenous knowledge systems. The second is that of 'temporality' in which the life-course approach assumes a normative developmental trajectory, thus undermining culturally meaningful understanding of rites of passage and life stages. The third is that the life-course approach does not take into account the current and unprecedented reality of human migration, which disrupts standardized notions of the life course and presents multiple trajectories.

White, Ramachandran and Kumar synthesize the evidence on the effect of mental health stigma on a range of life domains globally. In so doing, they emphasize the dynamic interaction between local explanations for mental health difficulties and experiences of stigma in those settings. For example, the role of explanatory models and patterns of self-stigma vary significantly across cultures. The authors draw attention to the paucity of evidence from LMICs regarding interventions to reduce stigma and highlight promising contextually sensitive approaches. They also warn against global anti-stigma campaigns that do not pay careful attention to local culture and meanings, pointing out that such initiatives could do more harm than good. The chapter provides a rich and densely referenced overview of the multifaceted and complex area of mental health stigma.

Kienzler and Locke focus on the area of violent conflict and its devastating impact on mental and physical health. They describe the critiques of the inappropriate transfer of western psychological assumptions to settings in which they may not be meaningful. The authors highlight what has emerged from the debate and show the need to build a richer cross-cultural understanding of mental illness in war and post-war settings. The chapter provides a broad view of violence and its impact on mental health, including structural violence, by which the chronic patterns of poverty and exclusion serve to marginalize and disempower populations. They also highlight the tensions between 'trauma-focused' and 'psychosocial' approaches to violent conflict, arguing that trauma-focused approaches may have their benefits but that these are not sufficient. They emphasize the importance of considering social suffering and local idioms of distress in the process of developing locally relevant interventions that emphasize the agency of individuals and draw attention to broader social ills.

Orr and Bindi argue that the focus of the field of GMH on the 'treatment gap' is misplaced and that the so-called treatment gap is not characterized by an absence but by complex and varied forms of treatment that are not easily captured within the framework of GMH. The authors present data to support the view that contemporary societies are characterized by medical pluralism: a situation where people choose (or are forced to choose) from a plethora of coexisting therapeutic options. This is presented as a challenge to the field of GMH, namely to engage with the questions that this medical pluralism raises. These questions include the epistemologies that define mental health issues, the effectiveness of different healing approaches and the politics and power of healing. During the course of the chapter, the authors provide an instructive history and overview of the study of medical pluralism and healing systems.

Stavert considers the importance of mental health law and human rights in the global context. The chapter begins with the WHO GMH action plan and its endorsement of the UN Convention on the Rights of Persons with Disabilities (CRPD). The author also provides an overview on current global legislative and human rights protection for people with mental health problems. She then summarizes mental health and human rights as they are addressed in the UN CRPD and other relevant human rights treaties. This is contrasted with the reality in many countries which offer scant human rights protection for people living with mental health problems. The author then highlights several challenges with implementing human rights standards for persons with mental health issues. These challenges include national constitutional arrangements and international law obligations, the rule of law and human rights, responsibility for the implementation of rights, the nature of rights themselves, ideological differences, societal attitudes, lack of information and resource challenges.

Boahen-Boaten and colleagues focus on suicide in LMICs. The chapter identifies risk factors for suicide in LMICs by synthesizing findings from a wide variety of data sources, including a systematic review of case-control psychological autopsy studies. A number of risk factors are identified, including intrapersonal, interpersonal and distal factors that interact in a complex manner—calling for a range of interventions from mental health service provision to broader macro-level policy interventions. The authors emphasize the importance of context in understanding the phenomenon of suicide. For example, there are marked discrepancies between countries in the prevalence of mental disorders in completed suicides, using psychological autopsy methods. The authors present a critique of the methodological weaknesses in some psychological autopsy research in LMICs. They also draw attention to the dearth of research evidence on suicide in low-income countries: while 85% of global suicide deaths occur in LMICs, only 10% of suicide research is conducted in LMICs.

Eggerman and Panter-Brick describe a study of mental health and resilience in Afghanistan. The study included a large sample of 1011 children aged 11–16 years, paired with 1011 adult principal caregivers and 358 teachers. A cohort of 364 child-adult pairs was followed over a one-year period in Kabul. They found that poor mental health, defined as probable psychiatric illness, depression and post-traumatic stress, was driven by gender, trauma exposure, caregiver wellbeing and geographical area. Everyday violence was shown to have as important an impact as militarized violence in the recollection of traumatic experiences by the children. The authors demonstrate the importance of contextual, subjective and social experiences in children's recollection of traumatic experiences. In their one-year follow-up in Kabul (with 64% of the original sample), they report the surprising finding that child and caregiver mental health had improved, although they do not indicate what proportion of child-caregiver pairs had improved or to what extent it had improved. This was in the absence of any provision of mental health services and with the presence of ongoing conflict, poverty and social instability. The quality of family relationships and ongoing enrollment in school were key predictors of improved mental health. However, post-traumatic stress did not abate over the year, suggesting distinctive pathways for depression and post-traumatic stress. Families participating in the study clearly articulated the political, social and economic threats to their mental health and wellbeing and the importance of hope in promoting resilience. Policy implications include the need for more structural interventions to strengthen families and provide the social and economic resources that can break cycles of economic instability, domestic crowding and domestic violence.

Common Themes and Differences

Three common themes emerge from these chapters. The first is that most authors endorse the importance of diversity and the need to respect what is 'local' in a global context. This includes diverse experiences of what might be identified by western psychiatric nosologies as mental illness (Mills and White), diverse experiences of stigma in the context of mental illness (White et al.), diverse experiences of life trajectories (Watters) and diverse treatments (Orr and Bindi). In many chapters, attention is drawn to how local context affects a variety of determinants of mental health status in local populations. For example, Eggerman and Panter-Brick provide a rich account of how local, cultural and economic circumstances affect the interface of violence and mental health in Afghanistan. Similarly, White et al. illustrate the manner in which local cultural meanings and explanatory models influence self-stigma and its relationship with mental health in diverse ways. And Kienzler and Locke argue for the importance of considering social suffering and local idioms of distress when designing interventions for victims of violence and trauma.

The second common theme is one of complexity. Several authors provide data to illustrate surprising findings that challenge universalist assumptions when engaging in mental health practice in diverse global settings. For example, Eggerman and Panter-Brick show that despite the ongoing conflict and social and economic fragility of the Afghan setting, children's mental health improved over time. It is perhaps less surprising that the factors that predicted improved mental health were family functioning and school enrollment. Nevertheless, the authors illustrate the importance of not assuming that mental distress requires only the provision of mental health services and argue that it may instead require the strengthening of social systems and creation of economic opportunities to promote social stability and mental health resilience. Similarly, Orr and Bindi provide a detailed overview of the reality of medical pluralism in contemporary global society, which illustrates the complex pathways that people suffering from mental distress negotiate in search for relief from their difficult experiences.

A third common theme is the lack of research on mental health, especially in low-income countries. Mills and White point to the dearth of evidence regarding the effectiveness of task-shifting approaches to mental health care in low- and middle-income countries. Boahen-Boaten et al. review the literature on case-control psychological autopsy studies of suicide in low- and middle-income countries, illustrating both the methodological weaknesses in the available literature and the lack of research evidence on suicide in low-income countries. Stavert highlights the lack of information when attempting to implement human rights standards for people living with mental health issues in diverse legislative environments.

Despite the commonalities, there are of course also important differences between the chapters. An initial obvious difference is in the foci of the chapters. Mental health issues in the global setting embrace a wide variety of fields, and the authors illustrate engagement with a diverse range of disciplines and topics. These include clinical issues such as diagnostic systems and treatments, experiences of mental distress and stigma in diverse cultural environments, human rights protection and legislative provisions, violence and conflict, poverty and social exclusion, suicide, family functioning, the meaning of community and how to engage communities and life-course trajectories and temporality.

The authors also demonstrate varying perspectives on current global initiatives in the field of mental health, such as those led by the WHO through its mhGAP program (WHO 2008) and the MGMH (Horton 2007). Unfortunately, the authors in several chapters dichotomize the perceived MGMH/WHO position and what the authors characterize as more nuanced views that take into account the complexity and plurality of communities and local reality. In short there is a tendency to polarize MGMH/WHO (bad) from apparently alternative and critical (good) views. For example, Mills and White criticize mhGAP for being largely based on mental health services in high-income countries and for attempting to export western psychiatry to low- and middle-income countries. Similarly, Watters criticizes the WHO and MGMH for advocating a 'life-course' approach as he believes that this is a form of 'epistemic violence' that assumes the universal validity of western psychiatric diagnoses and that it does not take into account diverse life trajectories in different cultural settings, especially those affected by migration.

This response is unfortunate, especially if one considers the work and writings of the individuals and organizations involved in the MGMH and WHO in more detail. A closer look reveals that they embrace a wide variety of positions and include a vibrant and critical community of scholars, activists, practitioners and people living with psychosocial disabilities. Indeed, many would acknowledge several of the criticisms voiced in this part as important considerations that must be faced as the fledgling MGMH attempts to find its way in the complex world of global health politics. To dismiss this grouping repeatedly as some form of monolithic front for Western psychiatry is an unfortunate and potentially destructive misunderstanding.

As an illustration, the recent conference of the MGMH in Delhi in November 2015 was largely organized by people living with psychosocial disabilities in LMICs—indeed the current leader of the MGMH is an outspoken advocate who has lived with psychosocial disability for many years and engages critically with psychiatric services. The conference included a dynamic program of testimonials, research, creative performances and networking of service users and practitioners from around the region and internationally. In relation to the mhGAP program, the WHO has openly encouraged the adaptation of the mhGAP Intervention Guide (which is aimed mainly at primary health care providers) to local cultural and healthcare settings. In the PRogramme for Improving Mental health carE (PRIME), we have gone to considerable efforts to adapt the mhGAP-IG to five diverse local settings in Ethiopia, India, Nepal, South Africa and Uganda (Lund et al. 2012), and we have done so with the WHO as one of our key partners. This has included developing culturally sensitive community-based case detection tools using local idioms of distress in Nepal (Jordans et al. 2015), integrating mhGAP into general primary care guidelines in South Africa (Petersen et al. 2015) and extensive consultation with local district stakeholders using Theory of Change workshops (Breuer et al. 2015).

This is not to say that the criticisms of the MGMH and WHO are not important. Efforts to scale up mental health services globally must be extremely careful to pay attention to local realities, to be respectful of local community-based healing systems, to critically engage with western nosological systems and to not repeat the mistakes of western psychiatric services. But to imply that the MGMH and WHO are not aware of these considerations or to somehow juxtapose these with more critical positions is to create unnecessary divisions.

However, not all authors in this part fall into this kind of dichotomy, and there appears to be scope in some chapters to consider some of the shortcomings of the young field of GMH without calling for its abolition. For example, in the chapter by Orr and Bindi, there is acknowledgment of the fierce attacks on GMH by Summerfield (Summerfield 2008), while also providing space for Patel to argue that a balance between universalist mental health frameworks and local understandings is possible in the field of GMH (Patel 2014b). Similarly, Kienzler and Locke provide a balanced account of 'trauma-focused' and 'psychosocial' approaches to violent conflict. And Burgess and Mathias provide a constructive framework to assist researchers and practitioners to engage with the complexity of community-based partnerships.

Critical Questions and a Way Forward

The juxtaposition of the 'global' with the 'local' raises a number of interesting questions for those of us involved in GMH research and practice. I will address each of these questions in turn, to propose a way forward and invite ongoing dialogue.

Firstly, how can we advocate to global audiences such as international development agencies about the need for global action and more resources for mental health, while remaining respectful of what is local, including local healing systems, resilience and culture? My own view is that we have to act globally, while paying careful attention to the evidence from what is local. Mental health has been neglected for too long, and many millions of people, particularly those living in poverty or civil conflict, suffer unnecessarily. To address the scale of the problem we cannot only rely on local piecemeal efforts when there is much to be gained from finding common ground and acting together. The reconciliation of the local and the global may not be as impossible as it seems (or is sometimes depicted). The key is in the doing, in becoming engaged in adapting and developing interventions using equitable and collaborative partnerships in diverse LMIC settings. We need a truly public mental health approach that simultaneously addresses the social determinants of mental health and provides culturally sensitive and evidence-based care to those in need.

The enormous challenge that we face is to build the evidence base for locally acceptable, culturally congruent detection methods and interventions. Crucially, this involves a combination of psychological, psychopharmacological, social and economic interventions that address both social causation and social drift pathways in the vicious cycle of poverty and mental ill-health

(Lund et al. 2011). In the last 5–10 years, there has been a blossoming of such research and practice in LMICs, through a diverse range of individuals, organizations and funding sources. To illustrate, we are engaged in such initiatives through PRIME and the Africa Focus on Intervention Research for Mental health (AFFIRM) (Lund et al. 2015), together with a network of research hubs in Latin America, sub-Saharan Africa and South Asia. These include, for example, a cluster randomized controlled trial of collaborative care models with traditional healers in Ghana and Nigeria, led by Oye Gureje and colleagues at the University of Ibadan. For this endeavor to move forward, it is vital that those who are critical of the MGMH and WHO engage in a constructive manner to build common ground for dialogue, rather than a wholesale rejection of global initiatives in a manner that can be extremely destructive.

Secondly, a very important criticism of the global approaches to the treatment gap is one raised by Mills and White as well as Orr and Bindi in this part, namely: is the treatment gap as large as it is reported to be? Vikram Patel has expressed a similar concern in what he calls the 'credibility gap' (Patel 2014a). In short, the treatment gap focuses on the supply side of the equation by calling for an increase in the provision of services, but assuming that once services are provided they will meet the needs of local populations and be taken up. The reality, as Mills, White, Orr, Bindi and Patel point out, is that frequently mental health services are not congruent with the way in which people in diverse cultural settings understand their psychological or mental suffering—hence a 'credibility gap'.

Once again there are enormous research and practice challenges in addressing this concern. Some of these challenges are methodological: we need to find more accurate means of defining and measuring contact coverage, treatment coverage and effectiveness coverage (De Silva et al. 2014). These may, in certain instances, serve as proxies for the extent to which services are acceptable, accessible and affordable for local populations and hence taken up. But there is also a crucial need for qualitative and ethnographic research, for developing and adapting interventions locally in a manner that is culturally acceptable, for partnerships with local traditional healing practices and engaging with and mobilizing local community structures. In our work in PRIME in Ethiopia, the Ethiopian team undertook an extensive process of community resource mapping in the Sodo district which revealed that 'the district is rich in community resources' (Selamu et al. 2015), and these have been crucial in the subsequent development of the PRIME Ethiopia district mental healthcare plan (Fekadu et al. 2015). The gap between those who do and do not access care when living with a mental health problem is not only about supply side factors but also about demand-side factors: the acceptability and affordability of local mental health services and the extent to which they resonate with the worldview of the local culture is critical.

Thirdly, what criteria should we apply when recommending interventions in contexts of medical pluralism—is it a case of anything goes, as long as it is culturally congruent? For example, certain traditional healing practices (and religious groups in high-income countries), practice beatings or chaining to remove perceived evil spirits from people suffering from what western psychiatry would identify as psychosis. To my understanding, we do need some principles by which we can operate. Two such principles that stand out are that interventions should protect or promote human rights (e.g., should be in line with internationally agreed treaties such as the UN CRPD) and should be empirically shown to convey benefit, in other words should be evidence-based. Both of these principles can (and should) be debated extensively. In relation to the latter, evidence does not imply, as some critics believe, selling out to western 'epistemic violence'. But it does imply a careful and respectful consideration of the needs and responses of local populations and the interventions that can promote journeys of recovery, while simultaneously drawing lessons that may be helpful to others.

Conclusion

This part of the book provides an excellent forum for debate and bringing together what might become polarized views. There is a great deal at stake for the fledgling field of GMH. For too long, mental health has been sidelined from international health and development policy. In an attempt to right this trend, advocates of GMH have adopted many of the arguments of global health, choosing to focus on what is 'global': the global burden of disease (using international diagnostic classification systems), the costs of mental illness, the need for evidence-based approaches and the necessary quantification of costs and impact of scaling up mental healthcare (Lancet Global Mental Health Group 2007). In so doing advocates of GMH have opened themselves to the criticism that they are not aware of (or even do not care about) the realities of local cultural experiences of distress—that they are not aware of the need to adopt caution in scaling up evidence-based interventions when the evidence base is derived largely from high-income countries.

This criticism is important, and it needs to be taken on board, particularly as we attempt to build the evidence base in LMICs. However, to some extent the criticism is also, I believe, misplaced and even ironic. It is misplaced because many of the leaders in the field of GMH come from low- and middle-income countries where they are profoundly aware of the plurality in local cultural idioms of distress. Examples include Ricardo Araya, who led the development of collaborative primary care for depression in Chile (Araya et al. 2003); Atif Rahman, who developed the healthy thinking program, using 'lady health workers' to provide cognitive behavior therapy for perinatally depressed women in Pakistan (Rahman et al. 2008); and Vikram Patel who pioneered the delivery of primary care for common mental disorders in India (Patel et al. 2003).

The criticism of GMH as being insensitive to local culture is also ironic because several of the leaders in the field of GMH began their research careers by examining local cultural idioms of distress. For example, Vikram Patel's initial ground-breaking research in Zimbabwe in 1996 focused on the reported experience of 'kufungisisa' (thinking too much) among primary care patients in Harare (Patel 1996). His work in this area led to his development of the Shona Symptom Checklist, a validated instrument whose items are based on local idioms of distress and which is now used routinely in primary care clinics in Harare to screen for the 'Friendship Bench' counseling intervention (Chibanda et al. 2011), an intervention which has benefitted thousands.

In short, notwithstanding the important criticisms of GMH, we may all have more in common than we think. And while it is important to have robust debate, it is also important to find common ground. There is a great deal at stake for the many millions of vulnerable and marginalized people living with mental health problems, particularly in low- and middle-income countries. Divisions in the field can dilute efforts to address their needs, both locally and globally.

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Part III

Case Studies of Innovative Practice and Policy

21

BasicNeeds: Scaling Up Mental Health and Development

Chris Underhill, Shoba Raja, and Sebastian Farquhar

Responding to the Global Mental Health Challenge

Mental health problems are increasingly recognised as a significant and growing contributor to the global burden of disease (Murray et al. 2012). The majority of people with mental health problems live in low- and middle-income countries (LMICs) and receive little or no evidence-based treatment, a situation often described as the 'treatment gap' (Lopez et al. 2006). This means that citizens of LMICs bear a disproportionate share of the burden of global mental illness (Whiteford et al 2013).

Moreover, the close links between mental health and development (MHD) are critically underemphasised. Conditions of deprivation or social exclusion increase the risk of mental illness (Lund et al. 2010) and reduce access to treatment and its affordability (Knapp et al. 2006). At the same time, mental illness exacerbates inequalities in wealth and income (Kessler 2008). Where social supports are inadequate, households are vulnerable to the income shocks created by mental ill health (Lund et al. 2011). Mental disorders reduce the ability of affected individuals and their carers to engage in productive activity

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as well as wage earning. This effect is especially large where stigma and social exclusion reduce the ability of affected individuals to engage in formal and informal labour markets (Sartorius 2007). The risk of stigma also reduces demand for treatment (Saxena et al. 2007).

In response to this situation, *BasicNeeds* was set up in 2000 as an international not-for-profit mental health organisation. The organisation delivers the MHD model in developing countries and has, to date, reached 631,441 beneficiaries through field operations in 12 countries in Africa, South Asia and South East Asia. Field programmes are operated either directly by *BasicNeeds* or through franchisee, that is, independent organisations licensed by *BasicNeeds* through a Social Franchise agreement to operate the *BasicNeeds* model (BasicNeeds 2014d, 2014e). *BasicNeeds* was founded by Chris Underhill who previously founded 'Thrive' and 'Action on Disability and Development'. Both organisations worked with vulnerable people affected by physical or mental disabilities. Lessons learned were applied designing the *BasicNeeds* model.

The *BasicNeeds* model of MHD, described in detail further in this chapter, comprises five modules: capacity building, community mental health, livelihoods, research, and collaboration (Raja et al. 2012). Taking a whole life approach, the *BasicNeeds* model addresses the health, social and economic needs of people with mental illness and their families. The model emphasises the importance of supporting the development of local institutions and community capabilities, participatory methods in all aspects of programme development, and grounding programmes in research on effectiveness (*BasicNeeds* 2008)

Operating in challenging contexts where as many as 85% of mentally ill people in LMICs are unable to access treatment or work opportunities (WHO 2004a), the *BasicNeeds* model has gained global attention for its innovative interlinking of mental health care, poverty alleviation and good practice (WISH 2013; Skoll Foundation 2013; Ashoka 2012; World Economic Forum 2014).

Working with colleagues in India, Chris conceived of the *BasicNeeds* model by listening to persons with mental disorders in rural and urban areas through a series of community meetings held in 2000–2001. Once the model was fully designed, *BasicNeeds*' first field programmes were implemented in India (BasicNeeds 2004). From 2002 onwards, MHD programmes were rapidly expanded to other countries in Asia and Africa. *BasicNeeds* works with communities and supports the health systems of LMIC to address the many challenges of Global Mental Health (GMH) in an integrated and holistic way (Lund et al. 2013).

The *BasicNeeds* model for MHD has emerged over more than 14 years. Within the framework of the MHD model, the finer details of implementation could differ from location to location depending on the needs of communities and the capacities of local systems. Because it is inclusive, it also depends on the conditions with which individuals present. In some regions, care is focused heavily on individuals with epilepsy, for example, while in others epilepsy is rarely treated.

This chapter introduces the *BasicNeeds* MHD model and describes its operations using examples from field programmes to demonstrate how each component of the MHD model aligns to the needs of the problem context. In the subsection on the 'Research' module, the authors elaborate on the method used to monitor *BasicNeeds*' impact on an annual basis. In addition, the chapter draws from papers and a recent independent review in India to illustrate key outcomes, discussing also some of the limitations. Finally, cognizant of the GMH community's consistent advocacy for scaling up, the chapter explains *BasicNeeds* experience and strategies in making the MHD model scalable.

Initial Engagement

Running a successful national MHD programme depends on identifying a region with a significant opportunity for improvement, understanding the local context and priorities and creating a partnership which builds on the assets of the communities involved. None of this can be achieved without performing a careful feasibility study in advance of implementing the MHD model.

The initial feasibility study involves reviewing the legislation and policy affecting mental health care provision, as well as the programmes and resources currently in place. In addition, estimates of baseline prevalence of illnesses must be made, although this can be difficult. These points establish the possibility and nature of improvement. For example, an initial feasibility study of Ghana's mental health services by *BasicNeeds* (2001) determined that existing services were limited and were hampered by lack of facilities and local practices, which marginalise people with mental illness from service provision. It identified that there were no existing plans to extend mental health services, either by the government or by non-governmental organisations, to the north of the country and the substantial logistical challenge created by poor transport links between the north and south. These made it difficult for individuals in northern Ghana to come to treatment centres in the south of the country (*BasicNeeds* 2001). This analysis informed the priorities of the programme in Ghana, leading to a focus on community-based self-help groups across a broad geography including northern Ghana (*BasicNeeds* 2014a). Feasibility studies help to identify different national or local priorities which determine how to adapt the MHD model for a particular setting.

Capacity Building

The first module 'capacity building' is broader than simply building the capacities of existing institutions to provide services. It involves engaging with affected individuals themselves, their caregivers and families, and others such as community leaders, traditional healers, local traders, health personnel, local officials, and so on. It crucially involves mobilising, sensitising and training stakeholders who will be involved in the implementation of the MHD model in one way or another. Executing this module involves the concept of *animation*, a core concept for *BasicNeeds* in building communities where MHD is practiced. This builds on a tradition in development work of enabling 'a higher degree of self-realisation, self-expression, and awareness of belonging to a community which they can influence' (Simpson 1989). Rather than imposing a solution on a community, *animators* aim to challenge and support a community to develop an analysis of its own problems, which will lead it, after reflection, to act (Underhill 1996). Thus, 'the animator has a special responsibility to stimulate people to think critically, to identify problems and to find new solutions' (Hope et al. 1984). Animation is an important component in which affected persons, often with low literacy, are involved in large numbers, and organised to create self-help groups. This allows communities to build ownership of their care.

Animation typically begins with field consultations, in which individuals with mental illnesses and their carers have an opportunity to discuss the problems they face as well as potential solutions. They begin by describing the people, organisations and experiences that shape their lives.

After they have an opportunity to discuss their world, participants move on to their needs and concerns. Lastly, they move on to the future and ask, 'what next?' From here, the group decides what they themselves can commit to resolving and where they require external help.

Gunasiri (a 33-year-old man affected by bipolar affective disorder) was one of the first participants of *BasicNeeds* programme in Sri Lanka. A volunteer who recorded Gunasiri's story writes:

> I first saw Gunasiri at the field consultation that was organized by *BasicNeeds* in the village of Rathmalwela. Not only Gunasiri, but his mother and father also

> attended that day. These three individuals who had come there in search of solutions to many problems of the mind, played key and poignant roles that day. In particular, Gunasiri had faced rare and unfortunate circumstances, not often faced by a man during his lifetime. At the close of the proceedings that day, Gunasiri was amongst the group of villagers that volunteered to form the committee representing the village, the Volunteer's Committee. They were invited to help BasicNeeds and its partner organisation, Navajeevana, in their work with people with mental disorders, getting their needs addressed, their problems solved and their expectations achieved.

This community-based approach is a powerful tool in the contexts where *BasicNeeds* works. In addition to empowering local communities and the individuals within them, it helps to overcome the shortage of trained psychiatrists and other mental health workers and the logistical challenges of travelling to remote specialist centres. *BasicNeeds* explicitly encourages the creation of self-help groups. These groups can provide peer support to help manage mental illness as well as to share information or raise awareness within communities. These groups can also form part of broader networks, which campaign for change on a regional and national level. This can involve collaboration with campaign groups for women's or disability rights (Underhill et al. 2014):

> Saidi Hamisi said he decided to join the Tuleane self-help group so as to join forces with people, lend a hand in farm production and raise awareness about mental disorders in Lisekese ward. … They have shown the community that they are capable of improving their lives. People are pleasantly surprised as they see this self-help group producing enough from their farming. The group sells their produce to neighbouring people. They are seen to be 'normal', like other people. Laiza said that when they wait for the harvest, she engages in other small businesses like selling vegetables, fruits and other necessities.—Laiza Jofrey's story, BasicNeeds Tanzania (2007)

In many localities, one of the main challenges is to sensitise the community to the nature of mental illness. This improves the ability of the community to later be involved in treatment and supporting livelihoods, but it also makes it easier for people with illnesses to seek help. Approaches taken include street theatre, personal counselling, sensitization workshops, consultations and media campaigns. *BasicNeeds* has found it helpful to focus these attempts on particular groups such as teachers, the police and judiciary, health professionals or schoolchildren.

Community Mental Health

> It is a long distance to go by bus and there's no money. If he is told to go alone, he wants me to go with him. We don't have money for two persons. One has to earn something to be able to pay!—Care giver from India, 2004

A key issue for building capacity for mental health services in LMIC relates to the lack of available human resources (WHO 2011). Trained professionals are often available only in major cities and they struggle to meet the demand placed on them. Individuals are hesitant to travel to the cities where treatment is available because of the associated transport costs and loss of productive working time. This reduces the extent to which individuals will seek diagnosis, because they have an accurate expectation of the lack of availability of services and the excessive cost of treatment (Saxena et al. 2007).

In *BasicNeeds*' experience, the key to improving availability is to provide services geographically closer to the individuals requiring treatment, as also advocated by the WHO (2008). One approach to this is to form a partnership with local health centres and community organisations. These organisations take the lead role in identifying and treating individuals with mental illness. Mental health professionals visit community health posts, clinics, community centres or health centres to provide additional training and support. An alternative is the use of mental health camps (Raja et al. 2012). A team of mental and general health professionals set up temporary facilities for a single day in order to provide treatment. This allows professionals to treat large numbers of people in a relatively short amount of time and to serve the areas most in need. This approach certainly has limitations, as professionals are able to spend very little time with each person. However, camps are backed up by home visits by trained community workers who provide the vital link between the family and the treatment facility (Raja et al. 2014). The community workers in most cases are already attached to primary care facilities treating communicable diseases, maternal and child-care, and so on, and *BasicNeeds* trains them to also address mental health.

The philosophy of *BasicNeeds* is to treat all individuals who present at the camps but the organisation appreciates the importance of outreach to identify individuals who could benefit and encourage them to attend. This work is often performed by community workers and volunteers (who are trained by *BasicNeeds*) and local mental health professionals. Follow-up support is provided primarily through the community workers. This is vital to make sure prescriptions are being followed, particularly where affected individuals are unable to read prescription instructions. However, ongoing supervision is important to ensure that local workers maintain standards, particularly where turnover is high (Raja et al. 2014):

> Eunice got to know of the mental health clinic through the community mental health volunteers in the area. 'George Ratemo comes from this village and knows that I suffer from a mental disorder so he informed us—my mother and I—that a clinic was starting in the neighbourhood in the beginning of May 2006. He even sent someone to keep reminding us of the date.—Extract from the life story of Eunice Wangeci Wambui Kihara, 25 years old female, diagnosed with Panic disorder, Kenya Programme. (BasicNeeds 2007)

Livelihoods

Mental health interventions, which neglect the context of poverty, risk ineffective delivery. This is partly because mental illness and the stigma surrounding it can be a causal factor behind a family's poverty. Many people with mental illness are unable to maintain paid employment, and illnesses can get in the way of other productive work (Razzano et al. 2005). In addition, the stigma of mental illness can reduce individuals' prospects indirectly by making it harder to acquire education. For example, Fatuma Mohamed, who participated in *BasicNeeds*' Tanzania programme commented: 'I wish to go to school like my fellow pupils, but I'm afraid of being called awful names' (*BasicNeeds* 2006a). Depending on location, this stigma can take multiple forms. In India, a fear that mental illness will harm marriage prospects can lead to it being hidden, and this is felt more strongly by women than by men (Thara et al. 2003). Thornicroft et al. (2009) found degrees of anticipated and experienced discrimination are consistently high among people with schizophrenia through a study across 27 countries (see chapter 13 by White, Ramachandran and Kumar in this volume for further details about mental health related stigma and discrimination).

Equally, having an occupation can help in sustaining recovery from mental illness (Bush 2009). Where individuals are able to engage in wage earning or other productive work, it can offer a renewed sense of purpose and feeling of meeting the responsibilities one has towards one's family. Participants of *BasicNeeds*' programmes have reported feeling satisfied that they no longer feel like a burden on their families, and are proud to be able to contribute. Regaining a sense of purpose can be part of managing mental illness. Nguyen Thi Mui, a 43-year-old woman from Vietnam, diagnosed with schizophrenia, told *BasicNeeds*:

> I have learnt how to make a broom and now I can sell it at the local market. It is very wonderful. Every day, I can earn 10,000 to 15,000 VND ($0.47–$0.72) so that I can buy some food for myself. My parents are very happy because I can overcome my illness.

BasicNeeds provides, alongside its community-oriented mental health treatment, interventions designed to enable affected individuals to engage in paid employment or other productive work. This first involves an assessment of the opportunities available to the individual, which includes the skills of the individual, the skills shortages locally and locally available institutions that can provide support. In addition to this assessment, *BasicNeeds* and its partner organisations visit affected individuals to offer support, mentoring and information about opportunities such as micro-finance initiatives. While some independent micro-finance organisations have been hesitant to offer loans to individuals with mental illness due to stigma, *BasicNeeds* has offered a subsidy in the form of a loan guarantee in some regions. This support can be accompanied by communities organising self-help groups as part of the animation process or communities supporting the affected individuals by identifying valuable activities they could work towards:

> Before he became ill, Venkatesh worked for thirty years in the weaving industry. He gave it up and concentrated on overcoming his illness with the support of his family. Following treatment and ongoing assistance from one of *BasicNeeds*' partners in India, Grameena Abyudaya Seva Samsthe (GASS), Venkatesh decided to set up a small business—supplying snacks to travelers using the bus shelter in his village. Trade has been good and he turns over about R.300 [$7.50] a day, a modest sum but comparable to the incomes of many people in the area. Most importantly, Venkatesh describes himself as having a completely new beginning. He is confident and contented, enjoying the relative freedom of the work he does now. Notably, the local panchayat (local elected body) has been instrumental in allowing Venkatesh to use the bus shelter, which is a favourable location for his business. (*BasicNeeds* 2006b)

Research

Global research on mental health is growing. However, local relevance of international epidemiological studies is limited. Furthermore, individuals with mental disorders, especially those who are poor, are marginalised due to stigma, their needs and valuable insights often overlooked by researchers and policy makers (Patel and Kleinman 2003). Of the small amount of internationally accessible mental health research conducted in LMIC, very little is practice based and people living with mental disorders remain largely unheard (Sharan et al. 2006).

BasicNeeds regards an evidence-based approach to improving practice and policy as highly important. The research module helps to embed a research 'culture' into the operations of the MHD model. The module facilitates evidence generation from field operations and also brings forth views of those affected by mental illness. The research module has two components.

Quality Assurance and Impact Assessment System

A standardised semi-automated quality assurance-impact assessment (QA-IA) system operates across *BasicNeeds*' programmes to monitor progress, reach and quality of implementation and to assess impact. Detailed protocols and standardised tools guide data collection. Both quantitative and qualitative data are collected.

Quantitative data comprises data of *individual beneficiaries* collected at baseline (i.e., at the time of their joining the *BasicNeeds* programme) and follow-up (collected annually from a sample of the total beneficiaries), and data of field *implementation*, that is, data on every activity carried out recorded regularly and systematically together with costs. Qualitative data comprises *Life Stories* and *Participatory Data Analysis* reports. The *Life Stories* are akin to semi-structured in-depth narrative interviews. Life stories of purposively selected beneficiaries are collected at baseline and updated annually to record narrations of their experience and perceptions. *Participatory data analysis* is an inclusive research process where participants evaluate the services they receive and also the change they experience. In a typical session, affected persons and their carers analyse their own data and discuss and summarise them under predetermined themes, often based on the MHD model, and suggest very practical recommendations. Through this method, they evaluate the intervention activities of the MHD model (Raja et al. 2012).

The quantitative analysis includes quarterly statistics assessing the progress of individuals: an analysis of implementation costs and results and an assessment of the scale of the programme. These are collected at a country level and are drawn annually into the organisation-wide impact report alongside qualitative analysis.

Providing econometric analysis to establish the impact of the MHD programmes is challenging given the scale and complexity of the operational context. Collecting and collating routine good quality data from every user from programmes across several countries is a huge task. Standardised high-quality training to field personnel and systematic quality checks at various stages minimises errors. Furthermore measuring cost per beneficiary is complicated by beneficiaries often accessing different interventions multiple times with varied frequencies. Detailed cost analysis is therefore done by activity factoring in also personnel time. This provides the basis for total cost per beneficiary calculations during a given period in a particular programme site.

A mix of qualitative and quantitative evidence combined with anecdotal narrations from different stakeholders provides a comprehensive picture of the actions and impact of the MHD model. Additionally, to mitigate the limitations of methodological rigour posed by the QA-IA system, an in-depth evaluation (mostly external) of the model is undertaken from time to time in different programme sites.

Evaluation of the MHD model

The outcomes of the *BasicNeeds* MHD model have been evaluated in Kenya (Lund et al. 2013) and the model has been case studied in Nepal (Raja et al. 2012) Additionally, all *BasicNeeds* MHD programmes are evaluated by external experts for performance and impact against the programme targets and deliverables as required by programme funders. We present findings from Kenya, Nepal and India.

Kenya

In Kenya, a cohort of *BasicNeeds* participants (*n* = 203) was assessed for general health, mental wellbeing, quality-of-life and economic activity before treatment and at 1- and 2-year follow-up. The study was carried out in a rural area, in the Meru South and Nyeri North districts of Kenya, and participants were enrolled from May–July 2009.

Participants selected were adults diagnosed with a severe mental or neurological disorder. They were selected from 529 individuals attending community engagement meetings and identifying themselves as having a mental health problem, of whom 408 attended psychiatric clinics, 317 were diagnosed with mental health problems. Individuals with substance abuse or moderate to severe intellectual disability were excluded from the study, leaving 203 participants. This selection was representative of the participants who receive support from *BasicNeeds* and is therefore an accurate reflection of the population being treated.

The study found significant improvements and large effect sizes in all assessments among the cohort, for example, almost tripling monthly median family income. A key limitation of the study was the inability to measure performance against a control group for ethical and practical reasons (Lund et al. 2013).

Nepal

The case study of the MHD model in Nepal analyses the treatment of 311 patients who registered between August 2010 and March 2011. Of those individuals who received treatment, 269 reported improvements during follow-up assessments by qualified psychiatrists, who recorded in individual clinical information sheets. There was also evidence of improved economic activity, with 15% of those not earning any income beginning to over the period, and 46% of those not engaged in any productive work beginning to do so (Raja et al. 2012).

Perhaps most markedly, 55 individuals showed signs of clinical improvement in the short time to March 2011. Of these, 31 were given some form of livelihoods support, which appears to have increased their earning power. Detailed business planning information was gathered, demonstrating that all 31 individuals became successfully employed, and the 6 who had previously been employed saw their earnings rise between 17% and 108% (ibid.). However, since this was a case study, the analysis does not feature a control group, does not define clear inclusion and exclusion criteria and makes no attempt to test for statistical significance.

India

The MHD programme in India, funded by Department for International Development (DFID), is implemented collaboratively by *BasicNeeds* with its partner Nav Bharat Jagriti Kendra (NBJK) in the states of Bihar and Jharkhand. This programme was recently evaluated by an independent evaluator (*BasicNeeds* 2014b).

Of those who accessed services through the programme, 53% reported a reduction in symptoms of mental illness, as recorded by the psychiatrists in individual clinical information sheets. In total, 41% of those who had access to treatment reported an improvement in social integration. This included acceptance by family members, community members and even selection as community representatives. There were reports of improvements in the marital prospects of women with mental illness, and that this further improved the marital prospects of their sisters (*BasicNeeds* 2014b). The overall cost per person supported was £59.61 over the course of the four-year intervention (an average of £14.90 per year) (ibid.).

The evaluation identified certain limitations to date. In Bihar, where the project was completed in 2014, there were reports that lack of access to medication was reversing the positive effect of symptom reduction. The evaluation also identified a need for continued support of advocacy groups as they learn to become independent in working with the government to improve the quality of care provision. It appears that men were over-represented in this project with only 41% of those seeking treatment being women.

A qualitative study evaluating peer support in the Ghana MHD programme indicated that membership in self-help groups appeared to be associated with more consistent treatment and better outcomes for those with mental disorders (Cohen et al. 2012).

Collaboration

Collaboration is a critical part of implementing the MHD model. Where collaboration is with an implementation partner, agreements are typically underpinned by a Memorandum of Understanding (MoU) which explicitly sets out shared values and principles, the relationship of the parties, planned activities to be carried out, the role of each organisation, the annual budget and a mechanism for dispute resolution. The MoU is supported by regular partner meetings, financial reporting and monitoring arrangements. *BasicNeeds* also typically perform regular skills assessments of partner organisations and provider additional technical training in key areas.

Effectively delivering mental health care depends on taking full advantage of existing resources and institutions. The treatment partnerships that *BasicNeeds* has forged have been mostly with state providers, for example, Ghana Health Services. The advantages of partnering with the state are many: the most obvious of which is the commitment to provide mental health services where no commitment existed before, an elementary but essential contribution to sustainability and replication. In almost all the countries that *BasicNeeds* works, medical staff from the state provide the front-line service in the clinics that are established. These staff are not particularly familiar with psychological treatments and indeed the numbers of clinical psychologists in government service are very few in number.

Where there is sufficient capacity, *BasicNeeds* has been able to offer a larger range of services through its partners. To give the best example, *BasicNeeds* has just finished a four-year programme in Thua Thien Hue province Vietnam, where district doctors were taught to administer rational emotive behaviour therapy to persons diagnosed with general anxiety disorder. This treatment was offered as treatment choice to patients and about half opted for the weekly sessions (*BasicNeeds* 2014c).

BasicNeeds is concerned to offer a service to a large volume of people and one-on-one therapy over a number of weekly sessions can slow down this goal. However, where the state provider has sufficient staff who can be trained in psychological therapies, the objective of reaching a large number of people is not impaired and the power of offering a choice of therapeutic approach is in of itself empowering. The *BasicNeeds* model in this context is flexible and can deliver effective treatment choices to patients.

BasicNeeds often acts to support and inform existing services as opposed to providing services directly. This trend is at work in the move towards franchising the MHD model to local partner organisations responsible for delivery (*BasicNeeds* 2013). For example, in *BasicNeeds*' programme in Nepal, a local organisation, Livelihoods Education and Development Society (LEADS), led most of the delivery. It relied on *BasicNeeds* primarily for training, support and liaison with other organisations such as pharmaceutical suppliers (Raja et al. 2012). Similarly, in Bihar and Jharkhand in India, *BasicNeeds* has been acting in a supporting role through its local partner NBJK (*BasicNeeds* 2014b).

Collaboration is not, however, limited to franchising and working through partners. It also includes fundraising, managing and building other sorts of partnerships, including relationships with governments as well as direct collaboration with community groups and existing self-help groups.

Over the years, *BasicNeeds* has developed a number of strategies for collaboration to help scale up and sustainability. At first, relatively standard design international programmes were developed in many low-income settings collaborating with a number of local organisations. The innovation was in seeing mentally ill people as being the central contributors to the development processes of their own countries. In many cases, more than one programme was developed in a given country thus giving good coverage and providing in-country opportunities for replication. With increasing experience in implementation, building capacities of local independent organisations was seen as the way forward. India was the first programme to establish its own board and register as an independent organisation. A few years later, Ghana and Uganda became independent organisations and more latterly, Tanzania also has just registered in the same fashion with Kenya intending to do the same thing in 2015. With independent programmes, *BasicNeeds* acts in a more supporting capacity (*BasicNeeds* 2013) to maintain quality, with in-country Boards taking ownership for effective implementation. Registering in their own countries also increased funding opportunities for the newly independent organisations.

Key Drivers and Challenges

There are a number of key drivers that have helped *BasicNeeds* sustain the impact of its programmes. First is the use of the MHD operational model that is wide in scope and inclusive of affected persons, carers and family, community, government and other key stakeholders. Secondly, offering clinical services and opportunities for work/income generation, which are facilitated through government and other local facilities and resources, helps build infrastructure and skills locally as well as generate positive attitudes for continuing service provision. Organising and building capacities of affected persons to self-advocate ensure sustained demand and pressure for effective provision of services (WISH 2013).

Equally there are many challenges. In each programme site, the everyday delivery of the model involves the execution of a planned set of interventions that translate into myriad activities carried out jointly by several agencies. This comes with innumerable problems, a spectrum of logistics, pooling resources, planning and coordination all operating under one umbrella—but made up of multi-disciplinary approaches, mindsets and conflicting priorities. This can result in compromises in order ‘to get things moving’. A first casualty here could be quality of the services provided since in many locations services are introduced for the first time with the start of the model implementation. Furthermore, often there is no policy or legislative backing that binds this collaborative work. In fact, creating that backing is a compelling part of the rationale for collaboration and scale up.

Other more specific challenges relate to keeping pace with demand and the acute needs of affected individuals and families while working through government and other existing local resources—an approach important for long-term sustainability. Persistent and skilled negotiations are required in working with psychiatric and health personnel as a majority of them are not familiar with the concept of a community-based approach. The non-availability of psychotropic medicines in the health systems to meet the increased demand generated from the community is a serious challenge in all countries of operation and often requires creative local solutions. Again, sufficient and consistent allocation of funds and other required resources from government are far from forthcoming, and successes here can often be small and piecemeal.

Scaling Up: Experience and Strategies

BasicNeeds has transitioned from being a delivery-oriented organisation to being a support-, research- and advocacy-oriented organisation, which enables partner organisations to build on its experience to create local programmes. This transition has been driven both by the global funding environment and by the perception that local collaboration and resourcing will have more long-term value (WHO 2004b).

Early *BasicNeeds* projects in India involved heavy commitment of on-the-ground resources relative to the size of the population served. At this time, *BasicNeeds* employed individuals who were primarily engaged in direct work assessing the needs of communities and developing appropriate interventions. It soon became clear that there were substantial capacity shortfalls in existing provision of mental health services. This led, in 2002, to the launch of a major project involving a partnership of *BasicNeeds*, *BasicNeeds* India Trust (a local organisation supported by *BasicNeeds*, which has now assumed independent control of *BasicNeeds* in India) and NBJK along with 25 other local partners (featured in the evaluation section). NBJK is a well-established non-governmental organisation that works in the states of Bihar and Jharkhand operating numerous field programmes that focus on vulnerable groups such as low-income families, women, children and adults with disabilities and mental health problems. This pattern of expanding reach by partnering local organisations with substantially greater operational scale would later be repeated in other programmes.

Several innovations in delivery enabled *BasicNeeds* programmes to scale effectively across socio-economic and geo-political contexts. Developing a codified model that outlines the major areas to be addressed in each intervention was one of these. Developing a standardised training package that is applicable for training in the MHD model in different countries and locations was another. In addition, scaling is supported by the standardised QA-IA system described earlier. The initial driver for this was a managerial one—it was valuable to get a picture of the resource distribution across *BasicNeeds* as well as to know who is being served and with what impact. This has been a crucial factor in allowing *BasicNeeds* to deliver programmes effectively across a much larger number of geographies than would otherwise have been possible.

Having collected the information, however, additional uses became evident. *BasicNeeds* is more able to partner academic institutions to carry out primary research into implementation of community-based development and mental health models. The evidence base also makes it easier for *BasicNeeds* to engage with policy makers in countries where programmes are in place to influence policies around MHD. Lastly, donor communities are increasingly interested in a robust evidence base backing claims of effectiveness.

Many of the other barriers to scaling have been overcome by emphasising partnership. Specifically, it became clear that the financial stability and sustainability of *BasicNeeds* was an important factor in its ability to continue to provide services across a wide range of geographies. By partnering local organisations to deliver the intervention, and by ultimately serving as an experienced knowledge partner, rather than simply as a delivery vehicle, *BasicNeeds* has been able to scale up more effectively, more quickly, and more robustly to serve more people than it could otherwise.

Developing the ability to engage in partnerships effectively depended on developing a standardised approach to due diligence for potential partners. This involves measuring their governance, financial, legal, HR and operation status. This allows *BasicNeeds* to ensure that partners have the capabilities necessary to become an independent partner, which will deliver the MHD model effectively. Local leadership is also a decisive criterion in identifying potential partners.

BasicNeeds places a heavy emphasis on partnership and collaboration with *communities, local organisations and especially also government* because this has helped faster scaling and effective adaptation to the local context far more quickly than a centralised delivery model could. There are a number of reasons why this is the case. First, local communities are essential to the economic inclusion of individuals with mental illnesses. Being engaged in productive work can give individuals a renewed sense of purpose and social engagement which can be effective in treating some mental illnesses and can improve wellbeing (Patel and Kleinman 2003). Often, the opportunities that enable individuals to engage in productive work depend on community engagement in two ways. They require communities to overcome prejudices and assumptions about mental illness, which marginalise or exclude individuals. They also can involve the proactive support of the community to create the opportunity.

Secondly, partner organisations allow *BasicNeeds* to leverage its experience and understanding across a much wider range of resources that can be garnered through a collaborative approach. For example, even when under-funded and staffed, existing national care delivery systems' budgets dramatically exceed the size of most development grants. Ignoring the ability to partner with government (often through its local arms) is missing a major opportunity. As seen earlier in the chapter, *BasicNeeds* programmes now routinely steer integration of mental health into primary care through task shifting involving specialists as well as non-specialists in changed roles in treatment provision (Raja and Wood 2008).

Thirdly, partner organisations allow *BasicNeeds* to learn from their experience of the local context. In no region has *BasicNeeds* simply transplanted their programmes from another region. Every environment has its own local context, which must be considered. For example, geographic conditions influence the importance of transportation in securing treatment. Access to microcredit influences the priority of using this tool for improving livelihoods.

Fourthly, existing organisations or individuals such as traditional and faith healers provide a large share of some mental health services (Abbo 2011). The nature of these services as well as the proportion of all mental health care provided by traditional and faith healers varies substantially depending on the region examined as well as the cultures present, levels of poverty or ethnic background (Sorsdahl et al. 2009). In some cases, a lack of understanding of mental illness by traditional and faith healers results in practices which can be counterproductive, for example, the use of toxic chemicals in treatment (Sorsdahl et al. 2010). Human rights abuses such as physical restraint and beatings can also occur. The United Nations special rapporteur on torture, Juan Mendez (2014), documented cases of physical torture, shackling, denial of food and water to mentally ill persons including children in psychiatric hospitals and spiritual healing centres of Ghana.

Conclusion

Jeffery Sachs, Special Advisor to the United Nations Secretary-General on the Millennium Development Goals, in his preface to the handbook on the *BasicNeeds*' model stated:

> Through its model *BasicNeeds* has proved that by working with people with mental disorders and their families in a holistic and participative way, their mental health can be improved and their levels of poverty reduced.

We can understand something of the nature of the changes created by *BasicNeeds* at the level of individuals by examining a typical story of a beneficiary from one of the oldest programmes operated by *BasicNeeds*:

> A young woman, named Huzeima, in Ghana was training to become a teacher when she became affected by an illness with caused her eyes to redden and prevented her from speaking as her tongue swelled. She also collapsed, overcome by fatigue. She was cared for by a traditional healer for six months, after which time she had recovered. Over time, however, she became forgetful and unable to associate with people.

> Huzeima was put in contact with BasicNeeds after attending a hospital where the nurse informed her of a consultation meeting at the hospital. After attending the meeting, Huzeima was diagnosed with psychosis at a BasicNeeds facilitated outreach meeting. As a result, she began to take medication.

> In addition, *BasicNeeds* put Huzeima in contact with a local self-help group, which provided Huzeima with a small loan she used to trade in grain. This provided her with a small income after repaying the loan, which stabilized her livelihood. The group was also able to arrange for her to be employed in a non-professional teaching role at a local school. Huzeima works there today, in addition to her work as Secretary of the Nanumba North District Association of mentally ill people and carers in Ghana.

We can see, therefore, that there are multiple smaller interventions which are facilitated by the presence of *BasicNeeds* and which developed as part of an ecosystem in which *BasicNeeds* took part alongside other governmental and non-governmental organisations. Huzeima benefited from access to medication, from a low-cost loan and from facilitated access to employment opportunities. In each of these cases, she benefited from a service, which would otherwise have been unlikely to be available.

The *BasicNeeds* model, when it was conceptualised in 2000, was an innovation because it brought development theory and practice to community-based mental health interventions. By implementing the MHD model in several LMICs in the last 14 years, *BasicNeeds* has gained valuable experience and knowledge bringing a wide range of alternative solutions to the current discourses of the GMH community, that is, essential alternatives to approaches limited to bridging the treatment gap.

Firstly, it is possible, and beneficial, to develop a generalised mental health delivery model which can serve as a template for local interventions in a variety of geo-political-economic contexts. It is important that the model includes enough flexibility to be adjusted to local contexts, but it can be useful for local contexts to have a framework within which to deliver their interventions.

Secondly, it is effective for organisations with an international spread to serve a quality assurance, policy, research, knowledge sharing and coaching role while local partners deliver the interventions making use of existing connections and relationships.

Thirdly, marrying development with mental health interventions is an effective strategy. Securing economic outcomes for individuals is a vital step in improving mental health. Projects which neglect livelihoods in delivering mental health outcomes are both failing to address a major risk factor and are neglecting to take advantage of the benefits which community involvement in livelihoods can bring (BasicNeeds; Livelihoods Education and Development Society 2010).

The *BasicNeeds* story is presented here as a case study of how mental health care can be combined with development and of how such an approach can be scaled up. Both are important for meeting the mental health challenge especially in LMIC where low resources, policy neglect and poverty of the affected families sustain the magnitude and complexity of the problem posed by mental disorders (UNDP 2012).

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22

Voices from the Field: A Cambodian-led Approach to Mental Health

Lucy Gamble

One day, one of my Cambodian colleagues greeted me with a smile and exclaimed, exuberantly and with joy, ‘You have put on weight’. My reaction was to become self-conscious and make a note myself to lay off the condensed milk in my coffee. In fact, his comments had nothing to do with my weight; he was trying to find a way to welcome me back warmly and tell me that he thought I looked well on my return from a few days off. Having grown up during the Khmer Rouge time, and subsequent years where food was scarce and many people were malnourished, this comment was intended as a compliment and reflected a perception of wellbeing.

Culture denotes how people understand and experience the world around them. It is transmitted through lived experience and is felt and experienced largely on an unconscious level. If a person lives in, and is a part of, a dominant culture, it can be hard to become aware of its influence. They are enveloped in it, like the fish in water. Stepping into another culture, an opportunity arises to become aware of the difference and edges between the guest and the host. Many factors start to come in to play that will influence the level of awareness of this difference: comprehension of the host country’s language, power dynamics, sense of professional certainty, and the expectations placed on others and self, to name but a few.

Within psychiatry, the Diagnostic and Statistical Manual and the International Classification of Disease diagnostic systems organize how

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symptoms are clustered and interpreted. The language and concepts drawn from these manuals are now used in countries with very different cultures to those in which they were initially developed, for example, the development of post-traumatic stress disorder (PTSD) within the USA for veterans of the Vietnam War (Young 1997). There is some evidence to suggest this is altering what is perceived as mental illness (Watters 2011). Academic journals (Errebo et al. 2008) and popular media (BBC News 2005) have documented the delivery of interventions developed within Europe and America, for example, cognitive behavioural therapy (CBT), to low-income countries as a way of supporting mental health programmes, or to provide emotional support to those who have been caught up in natural disasters such as the 2004 Tsunami. The Mental Health Atlas (WHO 2011) has facilitated comparisons of mental health resources and workforces between high- and low-income countries. The mhGAP (WHO 2008, 2010) initiative has called for the scaling up of mental health services within low-income countries. Underpinning this is a reliance on concepts being translatable of perceptions of health and wellness being similar to support the idea that models of mental health care can be 'adapted' and then rolled out in different countries. However, there are two questions that are particularly apposite here:

1. What are the implications of more of the same?
2. Are we assuming that these countries have not developed systems of understanding and intervention to support mental and emotional wellbeing over the centuries they have existed?

Kirmayer and Pedersen (2014, p. 764) have pointed out that 'local responses to suffering are embedded in cultural systems of meaning and healing that are part of the religious, spiritual, and moral fabric of communities and societies'. As such, mental health is expressed at a cultural level. Without an understanding of this, it is possible to wander into a minefield of misunderstandings, whether it be a superficial misunderstanding of a greeting, or on a more serious level, well-meaning but misjudged interventions. It has been argued that there is a creeping process of globalization occurring in mental health that is homogenizing perspectives (see Higginbotham and Marsella 1988). This has consequences in terms of the development and support of people's mental health and wellbeing for everyone. The homogenization of perspectives within mental health may lead to different perspectives and approaches being missed that could offer an alternative, or at least complement how psychiatry addresses the challenge of mental ill health and lack of wellbeing within the West. The adage 'If the only tool you have is a hammer, everything will look like a nail' seems appropriate here. Countries such as Cambodia challenge professionals and researchers to understand and approach mental health differently. Openness to this enables a more collaborative approach that will be of more benefit both there and for a wider understanding of mental health in general.

In 2002, I moved to Cambodia to work as a clinical advisor for a non-government organization (NGO), the *Transcultural Psychosocial Organization* (TPO) *Cambodia*.[1] Two years before I joined them, they had decided to become independent of TPO International that had been instrumental in starting the project in 1995 and to become a Cambodian-led organization. Rather than continuing a pattern of foreign experts visiting for periods of time, they decided they could be better supported by identifying people with the skills and knowledge they wanted and for those people to become TPO staff, living and working alongside them. I spent just over two years with them and have remained in contact since this time as the field of mental health has evolved in Cambodia. TPO has now been working in the field of mental health for two decades. Dr Chhim has been their executive director for the last 13 years.

Drawing on my experience of working for TPO, and continued contact with them, this chapter aims to explore four areas: firstly, Cambodian conceptualizations of mental health, in particular trauma; secondly, offer an outline of core components of TPO's programmes; thirdly, consider challenges that can occur when mental health professionals and concepts from the East and West come into contact; and lastly, reflect on the wider implications of issues raised within this chapter for Global Mental Health.

Cambodia

Clinicians will be familiar with the concept of taking a history to help formulate an understanding of a client to inform the intervention that will be offered. Therefore, an awareness of a country's history, its culture, and the experience of people at various levels within that context is essential when considering how mental wellbeing can be supported. This is particularly so when one accepts that mental health and culture are entwined.

Cambodian History

The ancient and powerful Angkorian kingdom began in AD 802 and continued until the late fourteenth century. It continues to influence Cambodians'

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[1] TPO will be used throughout this chapter to refer to TPO Cambodia.

sense of identity and culture. Following the demise of this era, Cambodia entered a period of upheaval and invasions. In 1873, Cambodia became a colony and part of French Indochina. As with any colonization, there was exploitation with the indigenous population placed in a subservient position.

During the Vietnam War, the North Vietnamese and *Viet Cong* used parts of Cambodia as a sanctuary. America began a programme of bombing these areas, which led to the deaths of many Cambodians. Political tensions that followed loss of power by the then Cambodian government set the scene for the Khmer Rouge (Glover 2001) who took power in 1975.

The genocide led by the *Khmer Rouge* is well documented (Glover 2001, Van de Put and Eisenbruch 2002). Approximately two million people died—around 25% of the population. Sweeping agricultural reforms were implemented, cities were emptied of people, and attempts were made to eradicate knowledge deemed incompatible with the new regime. 'Re-education', the rewriting of history and cultural heritage, and the development of a culture of fear were key aspects within this process. The family structure was undermined and attempts were made to subvert individuals' sense of the self in favour of a collective identity (Glover 2001). Among many groups that were killed were monks, educated people, trained professionals, and traditional healers. The loss of these healers dismantled the system of healing and led to a great loss of knowledge and skills.

Cambodia transformed from a traditional, family-centred Asian society into a state-centred, self-supporting communist state (Kiernan 1996). The Khmer Rouge period was a genocidal social experiment that has left a lasting legacy. It continues to have a profound impact on the psyche, culture, and environment of Cambodians.

In 1978, the Vietnamese Army invaded Cambodia. In 1989, a peace process began, reaching a ceasefire in 1991. The *Khmer Rouge* remained a strong guerrilla force up until the late 1990s, surrendering in 1998.

Current Situation

Multinational companies and other Asian countries, such as China, are increasingly investing in Cambodia. This brings a different set of values and potential issues (Nee and McCallum 2009; Van de Put and Eisenbruch 2002). Cambodia has a lack of infrastructure. This is particularly evident in rural areas where there is limited access to education, health care, and training opportunities for individuals. Approximately 20% of its population lives on less than $1.25 a day (CIA World Factbook 2014). Cambodia faces numerous challenges and sociopolitical issues, including widespread poverty (WFP 2015), pervasive corruption, lack of political freedoms, low human development (Transparency International 2015), and serious levels of hunger (International Food Policy Research Institute 2015).

The current government is led by Hun Sen, who has been in power since 1985. Cambodia has been described as a 'superficial democracy' (Roberts 2001). Opposition and demonstrations have been short lived. Although the extraordinary chambers of courts have been sitting in Cambodia since 2006 prosecuting senior *Khmer Rouge*, Cambodia's judiciary has been criticized as 'politicized and ineffective' (United States Department of State 2013). Controversy has surrounded Hun Sen's government and the trials.

In conversations I have had with Cambodians, it has been evident that they are acutely aware of the impunity of those with power. Challenging the status quo or being seen to be critical of those in power is something to be extremely cautious about.

Spirituality, Religion, and Community Structure

Cambodia's formal religion is shaped by the Theravada Buddhist doctrine. Prior to this, animism and Hinduism were present. Elements of these are still present and Buddhism in Cambodia is sometimes referred to as 'Khmer Buddhism' (Agger 2015). These beliefs influence people's worldview, responses to misfortune, poverty, psychosocial distress, and mental health and ill health; they form and shape coping strategies that people might adopt (Van de Put and Eisenbruch 2002; Ovesen and Trankell 2010).

Cambodian cosmology is based on a strict order; this translates into a hierarchal society and creates a map for correct behaviour. This in turn preserves order (Ovesen and Trankell 2010). Cambodia is divided into villages, communes, and districts and this hierarchy extends into these. Within each village there is a recognized structure including formal and informal positions, for example, village chiefs, village health volunteers, commune council members, traditional healers, monks, and elderly. It influences interpersonal interactions on many levels. Fatalism and karma are important elements of this (Chhim 2014) as are relationships with ancestors. When a person cannot organize the appropriate rituals at the death of a family member, the relationship to that person will be affected (Agger 2015; Hinton et al. 2013), and when order is disrupted (i.e. the correct code is violated), disorder of wellbeing, both mental and physical, can be caused (Ovesen and Trankell 2010).

Concepts of Trauma: Culturally Tied Concepts

Whilst living in Cambodia, I met a number of visiting researchers who spoke of their interest in PTSD and saw opportunities to develop their research. However, renowned traumatologist Judith Herman has questioned the validity of PTSD for certain traumatic experiences, in particular chronic trauma (Herman 2001). This questioning needs to be extended and applied to the cultural nuances of how trauma may be experienced, particularly as trauma relates to systems of meaning which are likely to differ across cultures.

Diagnosis can give a ‘neat’ narrative about health and patient presentations. In the absence of easily accessible alternatives practitioners may reach too quickly for it. Models of understanding offer a way of creating order and understanding, but they are not reality. The pressure to adhere to them is well documented, as are their limitations (Kleinman 1995; Summerfield 2008; Ovesen and Trankell 2010). There is a risk of exporting them at the cost of losing understanding of responses to trauma that already exist within the local culture, which may give more meaningful ideas about how to heal. Experts outside Cambodia may feel the trauma has been well documented, but this view is not shared by Cambodian experts. They have noted that ‘there is no appropriate Khmer language which can describe trauma in Western terminology and some meaning may have been lost in translation’ (Chhim 2012a, p. 652). Within Cambodia there is an absence of culturally reliable research that informs treatment of trauma within the Cambodian context (Chhim 2014).

Trauma Through a Cambodian Lens

Researchers have begun to recognize that the bio-psychosocial, symptom-focused model that had been offered by the USA and Europe is missing important dimensions within the Cambodian experience of mental health (Chhim 2014; Agger 2015). This model under-represents the prevalence and impact of trauma within the Cambodian population as well as framing interventions that are not addressing the Cambodian population’s need to heal from trauma appropriately (Chhim 2014). Cambodian-led research has been at the forefront in this, emphasizing a need to advance an understanding of Cambodian people’s references to trauma in the Khmer language and preserve indigenous health methods.

A Khmer term used to describe responses to traumatic experiences is *Baksbat*. *Baksbat* can be applied to describe an individual, a group of people, or a community. It can be caused by interpersonal, physical (both natural and man-made), and spiritual events (Chhim 2014). *Baksbat* can be translated into English in a number of ways; the most literal is 'permanent breaking of the body or spirit' and is summarized by the term 'broken courage' (Chhim 2012b).

The biological responses of 'broken courage' are similar to those described within PTSD. The additional element is a spiritual dimension (Chhim 2012a, b, 2013, 2014). The spiritual element is also reflected in Agger's (2015) research. As outlined earlier, within Cambodia, it is important to realize that the spiritual domain is a complex world; it includes relationships to ancestors as well as a sense of fate in relation to people's collective sense of wellbeing (Van de Put and Eisenbruch 2002). The spiritual beliefs, derived from Theravada Buddhism, influence how pain is understood. Chhim and Agger's research on trauma has shown it is not sufficient to acknowledge the spiritual element; there is a need to understand what this means within a Cambodian context. Cambodians see pain within a larger space of suffering and healing which is part of a process that influences interpersonal relationships, for example, within a family, contributing towards a sense of solidarity, reciprocity, and ethnic identity (Marcucci 1994). Pain is seen as part of life and unavoidable. These factors impact responses to suffering, that is, to traumatic experiences.

'Broken courage' is a concept that outlines Cambodian reactions to trauma through the current sociopolitical context in Cambodia. Although there are overlaps in features with PTSD, the areas of difference between *Baksbat* and PTSD influence treatment. Inclusion of the spiritual domain is not a minor cultural 'adaptation' as it significantly changes interpretation and response to traumatic experiences and this will be reflected in the healing process. Healing broken courage will be broader than creating a safe place to talk or a culturally adapted form of trauma-focused CBT. It is multi-dimensional. As Dr Chhim states:

> There is no medical prescription for courage. People have to be provided space that is free from oppression, intimidation, and abuse so they can begin to gain their courage and start again. A culture of support rather than of trimming.[2] (Dr. Chhim, 2015, Personal communication)

Dr Chhim clarified this by explaining how the treatment of *Baksbat* requires more than psychological or psychiatric treatment. It requires collaboration

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[2] In the time of the Khmer Rouge information, such as that an individual was educated or spoke a foreign language could lead to their death. This led to a culture in which people 'dumbed down' their background and disowned knowledge and skills.

and a collective effort on many levels beyond what might be considered to be within the typical role of a mental health worker or mental health organization. This also requires an understanding of the cultural context, including realizing that the spiritual component is likely to be core in conceptualizing mental health and therefore a core aspect of the intervention and healing process.

This reinforces the point that culturally appropriate conceptualizations of mental health and treatment needs to be captured from within a culture to be truly reflective.

TPO Cambodia: Who is Defining What Needs to Heal: Involving the Community

Any programme involved in mental health needs to be complementary to and, as an absolute minimum, informed about indigenous systems and beliefs about healing and managing distress. This is particularly important for communities who have come through the turmoil of conflict. In Cambodia, these conflicts threatened individuals' very existence as well as their culture. Tying interventions in with traditional beliefs and religious systems offers a thread of continuous identity at a time when communities are vulnerable to beliefs undermined (Van de Put and Eisenbruch 2002). TPO has built an approach based on this understanding.

Cambodian communities can be seen as interconnected systems and mental health as a dynamic within this. TPO appreciate that the community itself is the key resource and work alongside them to identify problems and resources rather than imposing interventions. They work through the structures that are already present within the villages, including the identified 'healers' and other identified resources. TPO acknowledge the intra-psychic nature of mental health whilst also understanding the importance of addressing the interpersonal aspect. Attempting to acknowledge and work with different aspects of the system rather than narrowly focussing on an individual increases the probability of effecting change. Long recognized within systemic therapy, systems are homeostatic and will readjust to attempted change to maintain homeostasis (Dallos and Draper 2005). TPO attempts to use an *emic* approach through using a context assessment, which will be outlined below. They then work horizontally and vertically within villages, trying to engage and influence key elements of the system to overcome its homeostatic tendency. Their understanding of Cambodia and Cambodian culture enables them to appreciate the 'rules' and nuances of communities, allowing them to work from within these rules to effect change within the system.

The culture of trimming that grew out of the *Khmer Rouge* time impacted on exchange of information and communication. Underpinning TPO's work is an intent to rebuild people's courage through facilitating communication about the difficulties they are facing and ways of addressing these using local resources. TPO believe the process of increasing social cohesion enhances community wellbeing. This approach incorporates an understanding of the intra-psychic nature of mental health and also the interpersonal and contextual factors. Psychosocial problems mediate mental health. Therefore a multidimensional approach is required which includes addressing issues such as poverty, domestic violence, and social justice. Within a hierarchical society coping with the challenges noted in the snapshot of Cambodia earlier in this chapter, the interests of those in the most powerful positions in a community may dominate and attempts to challenge this system too directly are likely to be ineffective. Therefore, sensitivity and a flexible, rather than programmatic, approach are essential in this process.

TPO partners with local and international organizations to support this approach. It sees itself as deeply rooted in Cambodian society and explicitly uses this as an anchor to guide its programmes. Seeking a dialogue with the communities it works with, TPO draws on an ethos of community mobilization. This enables it to develop an understanding of the communities' resources and their needs and involve them at the outset throughout the project design and implementation.[3]

Three core activities of TPO, which illustrate their approach, are community context assessment, training community resources, and self-help groups. These will now be outlined.

Community Context Assessment

Aspiring to work through community involvement requires awareness of the caution Cambodians have about challenging the status quo. To build confidence within communities that TPO is working respectfully within the current system, permission is sought from the government to work in an area. Once this is given, TPO respects the structure of villages and communities by seeking permission from the village council and leaders. Only once this is gained do they begin to explore how they can support a particular village.

TPO then conduct a *community context assessment* using a participatory rural appraisal (PRA). A PRA aims to incorporate the knowledge and opin-

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[3] Up-to-date information on the range of mental health work TPO is currently involved in is available on their website, http://www.tpocambodia.org.

ions of the community in question in the planning and management of any project. This is a collaborative approach that involves members from the community physically mapping out their resources, for example, pagoda, schools, access to clean water, older people, traditional healers, as well as vulnerable groups amongst the villagers. Through this process TPO staff begin to understand the current situation within the village and start to build up relationships with key stakeholders: village members as well as local authorities. This process forms the community context assessment. It is from this that plans are developed. It is worth noting that in thinking about mental wellbeing, TPO considers the social, spiritual, political, and economic dimension. If following the community context assessment, a key need is identified that would be better addressed by economic or skills development, TPO will link to an appropriate NGO to facilitate this for the community.

Training Community Resources

The next step of TPO intervention is training community resource people. There is a hierarchy within Cambodian villages, as described earlier. This includes formal and informal authority figures, for example, village chief, monks, and informal figures, older people. These local resources are the people that villagers are most likely to trust and from whom they seek help from when in difficulty rather than seeking hospital treatment. The cost of travelling to a clinic and of treatment, inconsistency of approach and reception, and most importantly, lack of familiarity and trust in how hospitals approach treatment create a reluctance to frequent them (Ovesen and Trankell 2010). The resource turned to is typically what is most familiar and is mediated by how the indigenous health cosmology influences understanding of a situation (ibid.). For example, if the perception of causation of a difficulty is attributed to spiritual elements, then a local medium or monk may be the person turned to for help. Thus, local resources within a village represent a resource within the community and are the people with whom TPO will work to support the wider community. TPO provide psychoeducation and support to them to learn how to recognize mental health difficulties and how to respond.

Role play, drama, and group discussion have been integrated into training to support trainees that have a low level of literacy to remain engaged. The training is provided by TPO staff over an extended period of time to allow the CRPs explore how they will use it in their communities with opportunities to liaise with TPO staff through this process. TPO staff also spend time providing psychoeducation to the whole village to stimulate interest and raise awareness. Figure 22.1 details an example of a poster used to discuss positive coping strategies within a Cambodian context.

There is a challenge for TPO in providing training and psychoeducation that reflects a wider tension between external and internal influences within Cambodia's current development environment. NGOs can undermine communities through creating imposed structures that are developed as part of a project that disrupts the established indigenous network of relationships and systems of support (Nee and McCallum 2009). This can happen when people are encouraged to engage with a project, as opposed to developing an initiative from within a community. A similar argument relates to introducing ideas and knowledge, and the potential medicalization of social and economic problems versus developing indigenous understanding.

Yet an issue for Cambodia is the loss of healers during the *Khmer Rouge* time. This has left a resource and knowledge deficit within this area. TPO are attempting to balance mobilizing communities and imparting information, whilst staying committed to developing indigenous understanding and responses to mental health through local resources. A gradual development of the latter is occurring, for example, through TPO's research on mental health, and this is increasingly supporting culturally appropriate interventions. This is an ongoing tension running throughout TPO's work.

Self-help Groups

TPO Cambodia trains key resource people to facilitate self-help groups in the communities. Given the level of poverty, and to support people taking time out from their daily duties, TPO sometimes provides a small amount of money to SHGs.

Fig. 22.1 A TPO Cambodia poster used to discuss positive coping strategies

Domestic violence (DV) is a significant issue within Cambodia and often a focus for SHG. DV represents another tension between internal and external influences within Cambodia, in particular how to respond. Poverty, alcohol use, a weak judiciary, economic dependence of women on men, and attitudes towards women in a hierarchical society predispose and perpetuate DV (Brickell et al. 2014). This contributes towards a culture of silence in which responsibility for maintaining harmony is placed on women. Those in senior positions, both formal and informal, in communities, often recommend reconciliation (ibid.). In 2005, Cambodia passed a DV law, although structural gender inequalities, discriminatory gender attitudes, customs and traditions, and weak rule of law have undermined its implementation. Therefore, 'choice' for women is limited through lack of viable options; this inhibits their ability to claim their rights (ibid.). TPO's approach to open up communication, involving people from across the hierarchy in a community, to discuss problems they are experiencing begins a dialogue in which difficulties can be recognized at an individual and intra-psychic level. At the same time, TPO staff encourage a shared responsibility to consider, and generate potential solutions to wider contextual contributing factors, for example, alcohol use and the broader implications of a culture of violence and substance misuse on the wellbeing of a community. Rather than directly challenging the system, it is through the cumulative effect of encouraging the system itself to reflect and generate small changes within and across it that TPO attempt to effect an enduring change.

I observed one group of women decide to buy some food and cook a meal together. The process of how they came to this decision, discussing what they wanted to do, working together to identify who had pots and utensils to enable them to cook a meal was significant, as was the process of preparing and working together and then sharing. This was a group of women living in absolute poverty in a rural, remote village with domestic violence. One of them was at that time struggling with significant violence from her husband. The women decided to give her the remaining food for the meal. This symbolic act was a powerful communication by the group to the woman of collective support and compassion, which had not earlier been evident.

Bringing people together to talk, to find ways to solve problems identified within a village, and to cope with emotional stress, appears well received by villages, particularly so amongst socially isolated individuals and those whose human rights have been abused and/or who are exposed to violence. Of note, I observed during counselling, particularly within rural settings, that there may have been an 'identified patient', but typically members of their family and village would join the session and contribute to the discussion. The person was not isolated to discuss their difficulties. There was an opening up of the discussion to involve the community. This challenges Westernized notions of privacy and reflects the observations of Ovesen and Trankell (2010) on the healing process in Cambodia, in which they describe the importance of social acknowledgement in healing. Agger (2015) also notes the importance of collective rituals in recovery. Thus, the approach of bringing people together in groups may be a better fit than attempts to replicate the Westernized approach of one-to-one treatment in which the individual is met in private, outside of the system within which they live.

Challenges for TPO

Some of the issues TPO Cambodia faces have parallels to those of organizations in the Western world: identifying staff with needed competencies, knowledge and personal qualities, for example, leadership, creativity, and ability to work as part of a productive team who adhere to the organization's values; managing staff in remote teams; and accessing financial resources; to name but a few. The most significant difference is the context within which TPO works, which is very dissimilar, for example, the impact of the Khmer Rouge period on human capital and critical thinking (Nee and McCallum 2009), and the current lack of a developed mental health care system as in the West (Agger 2015). In this part of this chapter, I will focus on two areas where East and West meet: (1) funding and (2) working directly with non-Cambodian 'experts'.

Funding/Donors

Poor mental health can cripple communities. Communities living in poverty and/or adjusting to experiences of war and trauma have a heightened vulnerability to poor mental health. Both of these factors are present in Cambodia. With no funding from the government for psychosocial work, NGOs approach donors for finance. Typically, donors are from outside Cambodia, and therefore accessing funds requires NGOs to shape programmes to meet the donors' priorities, which may be reflective of development priorities defined within the country of origin rather than Cambodia. This has led to a shift in TPO's programmes away from community development towards addressing gender-based violence and access to justice for women. The Khmer Rouge tribunal and work on truth-telling reconciliation, as part of the non-judicial measures for people involved in this, are trends TPO has responded to. Mental health remains as the core activity of the programme, but how this is framed has been altered in response to priorities defined outside of TPO and, often, Cambodia.

A common request from donors is that the project they are supporting needs to be sustainable. This seems like a reasonable aspiration, but it is important to explore what exactly is meant by this? What exactly is 'sustainable' within the current Cambodian context? Income from the provision of mental health services is limited. People cannot afford to pay and there is no internally funded system that could provide sustainable funding for them. In discussions with Dr Chhim, he highlighted his sense that funding mental health has never been a priority for donors. This has made it challenging to access finance to support mental health work. He is also aware that there is fickleness within the field of international donors, with the focus typically shifting to countries that have had more recent traumas and/or disasters. The Khmer Rouge period is receding in the minds of the international community, but its legacy in Cambodia is very present; this presents a worrying future for accessing funding for mental health NGOs.

Reviewing TPO's website in 2015 and previous organizational reports, it is notable that, despite being Cambodian-led and their awareness of Cambodian idioms of distress, predominantly Westernized terms are used in their descriptions of their work. I discussed this with Dr Chhim and asked about his work on *Baksbat*. His reaction was, 'I dare not take the challenge to the world who support PTSD.' His hope is to gradually introduce it into their research projects. 'Then I will try to see how (they) react and use the term before introducing it into clinical work.' He has no desire to challenge the concept of PTSD and sees its benefit clinically, but he is keen that Khmer concepts such as *Baksbat* are integrated into clinical work and that the Western concepts complement, rather than dominate.

The argument here is not who is right and who is wrong but about how best to treat, how best to heal, what it is that the person is seeking help for. An opportunity for healing is lost if the less dominant voices are silenced. Despite a growing number of academics and clinicians highlighting this (Agger 2015; Hinton et al. 2013; Van de Put and Eisenbruch 2002; White et al. 2014), it seems within mental health the voices of the Western funders are so strong they are drowning out Cambodian voices, even within Cambodia.

Working with Foreigners

Hospitals and healers within the traditional sphere, the spiritual sphere and the biomedical sphere were decimated during the Khmer Rouge time.

Despite the Cambodian government citing mental health as a priority, only 0.01% of the nation's US$2.6 billion budget ($300,000) is spent on mental health—with most of this allocated to the Phnom Phenh-based methadone programme (IRIN 2012; Chheng et al. 2012). This is possibly in response to the increasing incidence of HIV positive infections within injecting drug users, combined with advocacy and grants from the international community to encourage the Cambodian government to recognize the role harm reduction can play in containing HIV (ibid.). Outpatient clinics are limited. Whilst I was working in Cambodia, TPO supported hospitals to set up mental health clinics. The medical director of one particular hospital noted there was the most demand from the local population for this clinic each time it ran. The psychosocial work in the community that TPO offered also drew crowds of villagers. Clearly there is a sense of need.

Rebuilding the infrastructure to support mental wellbeing in Cambodia requires investment, support, and expertise. Much research and documentation is authored by non-Cambodians. TPO has taken on a valuable role in conducting research in the psychosocial field. Dr Chhim notes many TPO staff have only engaged in research when foreign 'experts' were working alongside them. The education system and upbringing in Cambodia does not encourage people to read. Consequently, TPO need to provide an extensive programme of internal training to encourage its staff to engage and prioritize learning and maintaining up to date knowledge, whether clinical or research based. The challenge for TPO is how it implements this within the resources available. One way TPO has attempted to address this has been employing foreigner advisors to work with them on particular projects for a number of years. This brings benefits to both, but also additional challenges.

I asked Dr Chimm about his and TPO's experiences of working with foreigners. He explained that TPO had experienced problems working with foreign staff. His experience is that they come with high expectations and standards: 'when they see us they tend to be disappointed'. He described how they then can become critical of the organization and behave in a way that Cambodian staff find patronizing. He felt that it was not uncommon for boundaries to become blurred at this point with them stepping beyond their 'advisor' role and behaving as the 'boss'. This experience occurred with a number of advisors and seems to represent a pattern.

Dr Chhim expressed consternation in terms of how to manage this difficult situation. 'I don't want to challenge the person. I want them to observe the dynamic of what happened while they behave that way.' This dynamic tends to jeopardize the very mandate that the advisor has agreed to. The foreigner may leave or move on to another post, after TPO has invested significant resources in them, and in the fragile financial environment in which it functions it cannot afford to squander them. In addition, a negative experience such as this is likely to impact on the morale and confidence of Cambodian staff. Interestingly, when asked what was success, Dr Chhim stated 'Success means that he start(s) to get people to co-operate (with) him and they all work together better'.

Having worked for Dr Chhim, I have immense respect for him, which has grown over the years as I have observed his patient and thoughtful approach to leading TPO and contributing to the field of mental health within Cambodia. I was left saddened by the message that seems to have been communicated to him through the behaviour of some of the foreign advisors:

> Now we get another advisor. I don't know, maybe I am poor. I don't know how to say it, that this is what they can see. Poor (compared) to what? To Western standard(s)? Maybe we are poorer, but what works and (does) not work? I think the way we do is in the right direction. I interview and try to touch base with (Cambodian) staff and they all agree, it is the right direction we take, their (our Cambodian) approach.

Cambodia is often described as a country of gentle smiling people. What I came to realize is that a smile does not mean agreement. Similarly, a lack of agreement may be expressed by absence of response rather than an explicit disagreement. It is often not what is said, but how it is said that denotes the meaning. Often all will be aware of this apart from the foreign 'expert' supporting the project. The majority of those who come to Cambodia to volunteer or work within the mental health field, including myself, have only a superficial grasp of the culture and often the language. The challenge of this is that the potential for true collaboration is weakened. The more I listen to Cambodian voices expressing their view of mental health and ill health, the more I am aware of this. I realize how generous and tolerant my Cambodian colleagues have been of my attempts to 'help' over the years. The learning curve, if you are prepared to climb it, is steep. Much of my time was and still is spent on that, often leaving me feeling that I have gained more than I have given. Becoming aware of the bias we hold and letting our grip soften on Western ideas about how things 'should' be done, or 'should be' is a process. Within this, there is a need to understand the meaning of these biases, how they influence our observation and interactions with others, and the implications of this in work with NGOs like TPO to support mental wellbeing. A talk given by the writer Chimsmand Ngozi Adichie (2009) captures this with the following statement:

> Our lives, our cultures, are composed of many overlapping stories … if we hear a single story about another person or country, we risk a critical misunderstanding.

Wider Implications

Caution is required in relation to the transposition of therapeutic models across different scientific paradigms. Globalization, contributing to a homogenization within mental health, has been highlighted (White et al. 2014). Yet, meaning and application of interventions change in different cultures, a process of indigenization (Ovesen and Trankell 2010) whereby particular historical and cultural backgrounds develop systems of meaning that frame experiences and influence behaviour. It is important not to make assumptions about perceptions of health, wellbeing or how treatment will be received, whether this moves from the West to the East (e.g. the interpretation and use of biomedical frameworks for prescribing) (ibid.), or from East to West (e.g. the use of meditation as an approach to self-soothing and emotional regulation within the West) (White et al. 2014), and the additional dimension incorporated in the East to attain merit for self and for the deceased (Agger 2015).

There is a responsibility to reflect on our own motivations and bias within the process of developing and delivering mental health interventions. Awareness of these, combined with a willingness to tolerate uncertainty, may be the first step in moving towards culturally informed practice. One element of this is the need for a broader understanding of mental health and possible solutions.

TPO's work highlights important issues in mental health delivery. Firstly, Agger (2015) notes the importance of religion for people healing from atrocities. Spirituality has also been discussed in relation to *counterflows* between high- and low-income countries (White et al. 2014). TPO's work reinforces this, opening up questions about the spirituality within mental health. This is an area that Western mental health services in their positivist, biomedical focus (Read et al. 2009) have largely distanced themselves from. I currently work in a community mental health team in an inner-city locality that is one of Scotland's most deprived areas. An aspect of their situation that keeps reoccurring in discussion with service users is a disconnection with a sense of self and the environment around them. Traditional cognitive models (Beck et al. 1987) fall short of addressing this. Across the West, there is a growing interest in third wave psychological approaches (Kabat-Zinn 1990; Segal et al. 2012; Gilbert 2010). The emphasis in many of these is on experiential leaning, developing a sense of connection and compassion to self and others. Is it possible this is reflecting a lean towards a spiritual dimension that has been largely absent in the West?

Secondly, ideas of wellbeing, ill health, and potential resources need to be drawn from the group that they are being applied to. The people and communities that are offered interventions need to be involved at every level of the process of delivery. Without this there is the risk of imposing models of understanding about their situation and solutions that may not reflect lived experience, or the priorities, values and needs of people seeking help. Absence of this not only reduces successful and appropriate implementation of interventions but may devalue and undermine resources and systems of support already present. This is relevant not only for the Global Mental Health community seeking to work across continents and countries but also for services within high-income countries, for example, the National Health Service (NHS) in the UK, in developing and delivering interventions.

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Synthesising Global and Local Knowledge for the Development of Maternal Mental Health Care: Two Cases from South Africa

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Introduction

Maternal Mental Health: The Global Situation

Maternal mental health problems are increasingly being seen as an important public health concern within the global arena and particularly within low- and middle-income countries (LMICs) (Patel et al. 2011; Saxena et al. 2007). A recent systematic review found rates of common perinatal mental disorders in LMICs to be 15.6% amongst pregnant women and 19.8% amongst women who had recently given birth (Fisher et al. 2012). This situation has not gone

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unnoticed, with widespread calls in recent years for the scaling-up of maternal mental health services in LMICs (Patel et al. 2011; Petersen et al. 2011). One of the dominant approaches for such scale-up is the deinstitutionalisation of maternal mental health care through its integration into primary health care and a shift towards community-based forms of care (Petersen et al. 2011; Rahman et al. 2013). Employing the concept of task-shifting/sharing, mental health care interventions would be delivered by non-specialist health workers, within existing routine primary health care as well as community settings.

Task-shifting is the predominant model that is being advocated on a global scale for the scale-up of mental health problems generally (Patel et al. 2011). This approach is seen as a crucial way in which to support overstretched public health systems, making a more efficient use of the human resources currently available. It is argued that task-shifting vastly increases the access points to treatment and care by reducing the 'bottlenecks' in the system created by a lack of staff able to perform certain tasks (Lewin et al. 2008).

Maternal Mental Health in South Africa

The maternal mental health situation in South Africa is similar to other LMICs, with maternal mental ill-health representing a large and growing concern. For example, in an informal settlement outside of Cape Town, almost 40% of pregnant women screened positive on the Edinburgh Postnatal Depression Scale for depressed mood (Hartley et al. 2011), whilst in an earlier study the rate of diagnosed postnatal depression was found to be 34.7% two months after childbirth (Cooper et al. 1999). Similarly, in a rural area of KwaZulu-Natal, almost 50% of women were diagnosed with antenatal depression (Rochat et al. 2011). As with other LMICs, services for maternal mental health are scarce and difficult to access in South Africa. Within clinic-based antenatal services, there is currently no routine screening or treatment of maternal mental disorders (Honikman et al. 2012). Although pregnant women may be referred to community mental health teams which have been established in some community health centres,[1] they face many barriers in accessing and utilising these services. The additional costs related to transport and child care, and loss of income to attend appointments, mean it is frequently unaffordable for many women. Furthermore, the overburdened nature of public services means that women frequently have to wait for a considerable amount of time before being seen, only further hindering adequate uptake (Van t'Hof et al. 2011).

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[1] Typically, these centres are variably staffed by psychiatric nurses with infrequent visits by psychiatrists and psychologists in training.

In line with Global Mental Health discourse, strong calls are being made in South Africa for the deinstitutionalisation and integration of mental health care services into primary care in order to increase the levels of treatment for mental disorders, including maternal mental disorders (Hartley et al. 2011; Petersen and Lund 2011). Indeed, the South African Mental Health Act (2002) and recent Mental Health Policy Framework state that mental health care, including maternal mental health care, should be integrated into routine primary care and community settings, using a task-shifting approach.

Voices of Dissent

There have however been various concerns within South Africa (Breen et al. 2007; Petersen 2000) and elsewhere (Campbell and Burgess 2012; Mills and Fernando 2014) that the widespread promotion of this particular model of care—that of deinstitutionalisation and integration through task-shifting/sharing—is too often being applied through a one-size-fits-all approach, which fails to recognise specific local socio-economic and political contexts. More specifically, it is emphasised that this model of care ignores the fact that health care services within primary and community settings in LMICs are extremely under-resourced and overstretched. Furthermore, the considerable work-loads and associated emotional stresses that health workers experience within such settings are being exacerbated by the current trend of task-shifting/sharing (Breen et al. 2007).

Moreover, it is argued that the widespread calls for deinstitutionalisation and integration are resulting in an emergent trajectory whereby only narrow, psychiatric interventions are being added to the workload of non-specialist health care personnel (Campbell and Burgess 2012). It is argued that this is ultimately encouraging the medicalisation of people's circumstances and increasing the availability of forms of care that are deeply steeped in biomedical ideology. As such, the structural factors which may contribute to mental distress in low-income settings tend to be side-lined (Mills and Fernando 2014) and a more comprehensive discourse of care marginalised (Petersen 2000).

In this chapter, we describe two maternal mental health projects, both based in the Western Cape Province of South Africa: the *Perinatal Mental Health Project (PMHP)* and *The Philani Plus (+) Intervention Program.* We demonstrate how in attempting to address the high prevalence of maternal mental ill-health and bridge the gap in treatment, both projects draw upon the global recommendation of task-shifting, but intimately entangle it with

South African realities, lexicons and matrixes. We describe these projects separately and explore how their main features are shaped by, and tailored towards, the South African context. We also consider some of the costs, benefits and potential replicability/transferability of these projects. In the concluding section of this chapter, we attempt to show how these two projects synthesise both global and local knowledge in relatively novel ways and in turn speak to some of the critical concerns that have been raised about the dominant model of care being proposed. We touch on what insights these projects may offer for the development of further maternal mental health services in South Africa and potentially elsewhere.

The Perinatal Mental Health Project (PMHP)

For women living in adversity, it is challenging to engage with mental health services when, in addition to facing competing priorities relating to poverty, violence and childcare, they are confronted with the stigma of mental illness. In South Africa, despite limited resources, antenatal uptake of health care is good, with estimates that about 95% of pregnant women are in contact with health care services during their pregnancy (Day and Gray 2011). Such high levels of contact with health services during the antenatal period thus present a unique opportunity in which to initiate screening and counselling services for mental distress. This was the impetus behind the development of PMHP. Launched in 2002, the project developed an intervention to deliver mental health care to pregnant and postnatal women in a collaborative, stepwise manner that is integrated into maternity care. The intervention has been incorporated into three primary-level midwife obstetric units which all provide antenatal care for women with low obstetric risk from the surrounding areas. In the following sections, we provide details of the intervention and how it has been adapted to the local context through developing a contextually specific screening tool, using a person-centred approach to care and training, and supporting health workers. We also consider the costs, benefits and potential transferability of PMHP.

Developing a Contextually Specific Maternal Mental Health Screening Tool

In order to facilitate entry in to care, a mental health screening process was designed to be integrated into routine history taking procedures as part of the first 'booking' antenatal visit. The Edinburgh Depression Scale (EDS) was used to screen for depression and anxiety symptoms as it has been validated in a wide range of settings globally, including in South Africa (Vythilingum et al. 2013). To supplement this tool, the Risk Factor Assessment (RFA), was developed, involving compiling 11 risk factors into a binary 'yes/no' questionnaire. These factors were drawn from local and global literature, as well as the experience of local health workers in the field. The RFA was introduced to detect contextual conditions that make emotional distress likely, due to concerns over the socio-cultural validity of symptom-related items on the EDS. Women qualified for referral for a counselling intervention on the basis of a positive EDS screen (>12, as per international convention and local validation studies) or on the basis of experiencing three or more risk factors on the RFA. Over time, it was noticed that maternity care staff struggled with the Likert-type format of the EDS, which requires more time and more complex score calculations than the RFA. Thus, the PMHP is in process of designing and validating a very brief 'yes/no' screen that includes symptom and risk items (Van Heyningen et al. 2014). All screening instruments have been translated and back-translated with health staff and service users into the three official languages of the province as well as French.

Providing Care Through an Ongoing, Person-centred and Psychosocial Approach

At the first antenatal 'booking' visit, maternity staff or PMHP counsellors provide psycho-education to mothers in the waiting room through informal discussion and the distribution of patient leaflets designed by the PMHP. Each woman is then actively engaged in an informed, written consent process as part of routine 'booking' procedures, which reduces stigma and enhances the acceptability of the service, whilst increasing uptake. Wherever possible, when engaging with clients, staff are trained to used generic constructs of 'support' and 'help' and to avoid medicalised constructs of 'manage' and 'treat'.

Women for whom screening yields a positive cut-off are referred to receive individual, face-to-face counselling by an on-site counsellor who is a trained, non-specialised health worker. Two of the counsellors are nurses with counselling qualifications, and the third has a four-year practical psychology degree. All of the counsellors within PMHP receive weekly supervision by a clinical psychologist and peer supervision every two weeks, and they all have the opportunity for self-care programmes and continuing professional development training. Each woman is assigned to a single counsellor, who then becomes her 'case-manager', providing the counselling and managing necessary referrals and follow-up.

A range of psychosocial therapeutic modalities is employed in the counselling, depending on each individual woman's needs and circumstances. These include psycho-education, interpersonal therapy, bereavement counselling, debriefing of traumatic incidents, cognitive behavioural therapy and suicide and impulse risk management, most of which have been evaluated in other low-resource settings in range of cultural contexts (Bolton et al. 2003). The focus is on containment, the building of self-esteem, enhancing resilience and the facilitation of access to social support, with the ultimate goal of overcoming the clients' distress and addressing problems presented at the initial counselling session.

The large proportion of francophone refugees required that a French-speaking counsellor be available. In addition to speaking the same language, it is felt that a francophone counsellor is able to identify factors which may be masked to an 'outsider', including cultural differences in expressions of distress and the effects of the local context on a displaced person. For example, Congolese women who undergo caesarean section for their delivery are frequently shunned by their partners or families. An operative delivery is considered to indicate a profound failure of the mother as a woman and parent, and there is significant associated conflict and anxiety. One of the PMHP counsellors, a nurse-midwife and a Congolese immigrant herself, and fluent in many languages spoken in the Democratic Republic of Congo (DRC), is able to work with these families to shift unhelpful attitudes and practices. The other counsellors are fluent in English and Afrikaans, the most commonly spoken languages of the province but are not able to speak isiXhosa, the African language also spoken in the province. However, all counsellors are well briefed on typical cultural and linguistic idioms of distress and engage with isiXhosa-speaking nursing staff and doctors in regular formal and informal meetings to discuss these in general, and when necessary, for particular clients.

The care provided is continuous, involving rigorous and personalised follow-up and monitoring. Thus, for example, if a woman is unable to attend the facility, or does not attend an arranged counselling appointment, she will be contacted by her designated counsellor to provide support for her attendance or offer telephone counselling. Similarly, if a client is referred to an allied health worker, her counsellor retains the central role in therapeutic management and will regularly liaise with the referral therapists. In addition, at six to eight weeks post-birth, the counsellors also conduct telephone or face-to-face postnatal assessments to explore the birthing experience: how the women are feeling and coping, how they are adjusting to life with the baby, their experience of counselling, and whether further intervention or referral to external resources is required. The counsellor can continue to provide each of their clients with counselling for up to one-year post-partum. The tracking and follow-up systems are time-consuming, yet necessary to overcome, in part, the many barriers women face in accessing mental health services. These barriers may be linked to stigma and fear but are frequently linked to logistical issues such as child care, transport costs and loss of earned income. Ultimately, the follow-up systems help ensure a continuity of care and the longer-term benefit of the intervention.

Case Example

[This case study was constructed by the author SH to reflect a common set of circumstances faced by many PMHP clients and is not based on any one particular woman's experience]

Sophie is 26 years old and in her third pregnancy. The father of her first two children was a gang leader and was killed a couple of years ago. Her current boyfriend is regularly drunk and verbally and physically abuses her. At her first antenatal visit, the counsellor chats warmly and informally with the group of mothers in the waiting room. A discussion flows about the difficulties that mothers face around pregnancy, the different ways in which they may suffer and the different ways in which they cope or may be helped. Sophie finds the counsellor very gentle.

After her mental health screening scores indicate that she may benefit from some counselling support, the nurse offers for her to see the counsellor. Sophie agrees and an appointment with the counsellor is scheduled for her next antenatal visit as she is unable to attend earlier. In the meantime, Sophie is given some reading material on mental distress and pregnancy as well as the contact telephone numbers of organisations or the PMHP counsellor that she may call for urgent support, if needed.

In four antenatal sessions with the counsellor, Sophie's feelings of abandonment and low self-worth are discussed. The counsellor enables her to see how these may contribute to the cycles of violence in which she is often placed. Together, the counsellor and Sophie explore positive examples of Sophie's prior problem-solving approaches and examples of her resilience in the face of adversity. With a greater sense of agency and self-worth, Sophie is encouraged to re-establish ties with her sister from whom she had become estranged. She is also encouraged to go back to her sewing circle which she had left after her bruises had caused her deep shame.

By the end of the pregnancy, Sophie has broadened and deepened her circle of support. She reports that by learning to anticipate her boyfriend's rages, she can better manage to keep herself and her children safe and that, although he still shouts at her when he is drunk, he has stopped beating her. At the six-week postnatal call, Sophie asks whether she can see the counsellor again to discuss her difficulties with parenting the older two children with the addition of the new baby. Two further sessions take place where parenting skills are discussed and Sophie's mothering is affirmed.

In-depth Engagement with Health Care Workers

The PMHP recognises that the occupational context in which health staff work needs to be addressed before mental health care can be integrated into primary care services. In South Africa, the public health environment is characterised by extreme scarcity and stress. Still carrying much of the burden of the legacy of apartheid with its inequitable distribution of human and financial resources, public sector facilities experience substantial overcrowding and staff shortages (Breier et al. 2009; Coovadia et al. 2009). Public sector nurses are thus expected to carry a considerable workload and have little recourse to supportive services or debriefing for their own mental wellbeing.

Within this occupational context, experiences of emotional exhaustion and compassion fatigue are common experiences amongst nurses, adversely affecting the nurse-patient relationships and the quality of care (Jewkes et al. 1998). The psychological phenomenon of 'othering' as a form of 'depersonalisation' is routinely identified as a coping mechanism in primary health care settings in the country (Rothmann et al. 2006). Consequently, health workers often distance themselves from their patients emotionally, which in turn prohibits empathic engagement and the provision of quality care. This process of polarisation in the relationship is exacerbated by the historic and current status differences (class, educational level, ethnicities) between nurses and mothers and results in a significant number of cases of abuse and neglect of clients, particularly in maternity settings (Coovadia et al. 2009; Jewkes et al. 1998).

Taking cognisance of this complex context, PMHP focuses a considerable amount of attention on the health workers themselves. A training programme has been developed which aims to improve mental health literacy and empathic engagement skills and to address the emotional wellbeing of nurses, midwives and staff involved in working with mothers. Training modules are highly interactive with use of case studies, role play and debate. These modules seek to draw out the innate wisdom of participants and optimise the use of existing emotional and practical resources. The training is supplemented by written PMHP resources provided to participants, resources which were developed in collaboration with a range of health workers who had been immersed locally in the fields of social work, midwifery, obstetrics, psychology, psychiatry and public health in resource-poor settings in the country.[2]

A critical focus of the training is to enable staff to develop an awareness of their own cognitive and emotional processes and to develop strategies to support their mental health needs. Here the PMHP developed its 'Secret History' method as part of its training programme (Field et al. 2014). Using a participatory, experiential learning approach, the focus of the method is on reconnecting health workers with the potential experiences of psychologically distressed women, whilst at the same time working with nurses to engage with their own mental health and emotional needs.

The secret history method involves two trainers facilitating a three-hour session with 10–20 participants of similar professional level. The method is highly interactive and focuses on group role play which immerses participants in the typical narratives of a pregnant mother and an overworked health worker. Half of the group takes the role of the health worker and the other half, the mother. Over time, new background information is revealed for each character and the facilitators enquire about what the participants are feeling and needing, as their assigned character. Half way through the narrative, the participants swap roles. In the debriefing component, interpersonal interactions and internal processes are examined in a participatory way. The training concludes with staff developing their own plans for being more aware of and responsive to the needs of patients and themselves.

For PMHP, this approach to training is essential for ensuring the provision and sustainability of quality mental health care within a primary care setting. In LMICs, however, participatory and experiential approaches to developing health worker capacity generally (Lehmann et al. 2008) and specifically in relation to mental health (Kauye et al. 2014) are rare. Although there has been a strong focus on primary health care worker training, approaches tend to be didactic in nature, focusing predominantly on technical expertise and knowledge acquisition (Goldberg and Gater 1996; Cohen 2001). Indeed, in South Africa, primary health care nursing qualifications and training have been criticised for the limited attention they afford to the interaction between nurse and patient (Breier et al. 2009).

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[2] These resources are available here: http://pmhp.za.org/learn/pmhp-resources

Costs, Benefits and Potential Replicability/Transferability

In 2011, it was calculated that it cost PMHP R185 (US$22.50) to provide maternal mental health services to one woman for one year. This included as many counselling sessions as she needed, the counsellor's liaison work with psychiatric services and social support agencies, and postnatal follow-up care. This can be compared to the average rate of private-sector psychotherapy which is R700 (US$85.00) per hour for one individual counselling session alone (PsySSA 2012). Although PMHP's mental health services were initiated with volunteers providing counselling, it became clear, as uptake increased, that a project coordinator and funding for basic costs were necessary for the smooth running and sustainability of the service. PMHP covers these costs through a variety of sources, namely philanthropic foundations locally and internationally, the Department of Social Development Western Cape, individual donors, the corporate sector and research funding agencies. PMHP's operations were formalised when it relocated into the University of Cape Town. This relocation was significant, affording the project considerable support from the institution for operational overheads and the infrastructure to access funding from donor organisations, as well as providing the project with access to expertise for the evaluation and further development of the intervention

In terms of the effects of the projects, a preliminary evaluation of the follow-up calls made by counsellors in 2011 ($n = 276$) indicated that 90% of clients reported that their primary problems had improved, 71% reported they were coping at follow-up, 74.6% reported positive mood, 95% reported successful bonding with their baby and 93% of women viewed counselling sessions positively (Field et al. 2014). Furthermore, a study conducted between January 2010 and December 2011 which investigated the use of PMHP services at one of its facilities found that, of the women who attended counselling, the majority came for two sessions or more, and most of these women did not default any counselling appointments, suggesting that the women found the service satisfactory (Baron et al. 2014). Interestingly, the study found that women with more children were more likely to default several counselling appointments compared to women with no children, suggesting that child-care responsibilities make it potentially more difficult to attend health care appointments.

In addition, an external qualitative evaluation found that staff benefited from improved capability to identify and assist with mental health problems (Chesselet 2005). Rather than adding a burden to their workload, staff reported a sense of relief that systems have been developed to meet previously ignored need. Furthermore, the study found that the uptake of training and associated enthusiasm amongst staff was further enhanced when participative methodologies were used. The staff reported that this gave them a sense of empowerment to address their own and clients' psychological distress.

Ultimately, these findings suggest high levels of acceptability for, and significant benefits of, the PMHP services which can be provided at a relatively low cost and delivered in considerably busy, low-resource facilities. However, if the model were considered for application elsewhere, certain key issues would need to be carefully considered. For example, PMHP sites are all situated in urban areas, where the availability of resources and the quality of health care are considerably better in comparison to rural areas. Furthermore, given the high antenatal attendance in South Africa, women's first antenatal visit provides a suitable and effective opportunity to initiate contact and screen pregnant women for mental distress. In situations where women do not attend health facilities regularly in the perinatal period, careful thought would need to be given to what would be the optimal environment to reach, screen and provide mental health care to women. In addition, the use of telephone calls as the primary mode of follow-up is feasible in South Africa, where there is high mobile phone ownership, text messaging services are relatively cheap and 'please call me' messages can be sent free of charge. Although a similar pattern is true in other African countries (UNDP 2012), this may not be the case in all low-resource settings, where alternative means of follow-up and continuous care, factors inherent in the model's success, would need to be considered.

The Philani Plus (+) Intervention Program

Like the PMHP, the Philani Plus (+) Intervention Program also employs a task-shifting approach to address the high prevalence of maternal mental disorders and bridge the current treatment gap. Unlike the PMHP however, the Philani Programme's task-shifting approach seeks to move mental health care beyond the clinics into a community setting. As touched on in the introduction, pregnant women face many barriers in accessing and utilising clinic services. The development of community-based health care is thus one way of confronting these challenges (Lewin et al. 2008).

In South Africa, however, and indeed many LMICs, community-based health services tend to be highly fragmented, involving interventions which target single diseases and outcomes (le Roux et al. 2013). There are a number of reasons for this, including disease prioritisation dictated by lack of resources, and the way in which global funding tends to focus on single diseases rather than, for example, family health or wellness. This fragmentation has led to a duplication of services, ineffectual surveillance, and unnecessary increased financial burden for people who are forced to undergo multiple interventions rather than one comprehensive service (Cecchini et al. 2010). Indeed, such separation ignores the fact that pregnant women frequently experience the co-occurrence of various chronic conditions which share many epidemiological features and risk factors (O'Connor et al. 2011). Ultimately this separation of services reinforces the common barriers to health care access and utilisation that community services are attempting to address.

Taking heed of these limitations, the Philani Plus (+) Intervention Program provides mothers and their children with simultaneous support for multiple health conditions and behaviours, including maternal depression and associated risk factors. The original Philani Programme was developed by a non-governmental organisation *Philani* over 30 years ago within informal settlements in Cape Town (Rotheram-Borus et al. 2011; Tomlinson 2014). Established as a community health worker (CHW) home-visiting programme, the focus was on preventing malnutrition, rehabilitating underweight children and promoting good health. The Philani Plus (+) Intervention Program builds on this original programme by integrating content and activities to address HIV, alcohol misuse and mental health. CHWs referred to as 'Mentor Mothers' (MMs) are recruited from the township neighbourhoods and trained to deliver a variety of home-based interventions. Each MM systematically visits all mothers in her assigned neighbourhood to identify those most at risk for health problems and who might not present at clinics. For those mothers who are identified as at risk, typically four antenatal and four postnatal visits are then carried out, or more depending on specific needs.

In the following section, we provide details of the intervention, including how MMs are chosen, trained and supported, as well as how care is provided through a person-centred and pragmatic problem-solving approach. We also consider the costs, benefits and potential transferability of the programme.

Developing a Contextually Appropriate Cadre of 'Mentor Mothers'

A key aspect of the programme is the necessity of recruiting MMs that are embedded in, and appropriate for, the context in which the interventions are delivered. As such, the programme draws on the concept of 'positive peer deviants' developed in Haiti in the 1980s (Berggren et al. 1984). This concept refers to mothers who are raising healthy and well-nourished children who are thriving in the community, despite living in the same poor neighbourhoods as their peers. The underlying principle is that these mothers are best placed to deliver services to others.

A rigorous, three-stage process is employed to choose contextually suitable MMs. Firstly, Philani engages with community leaders to identify the needs of the community and nominate mothers. Thereafter, these nominees are visited at home by Philani workers in order to observe routines and confirm that their households meet the criterion of ‘thriving’, including, for example, that the home is organised, that children are being appropriately looked after, and that healthy food is available. Those mothers whose households appear to be ‘thriving’ then undergo training, where they are meticulously assessed through interviews, written exams, as well as their performance on practical application of tasks and general attitudes displayed. The selection process is thus extremely stringent, with only about 50% of potential MMs remaining at the end of the training process.

Ongoing Training and Support for the Mentor Mothers

In South Africa, inadequate training, supervision and support have been identified as major factors contributing to the high attrition rates and poor performance of CHWs (le Roux et al. 2013; Lewin et al. 2008). The programme thus prioritises engaging with and supporting the MMs in an ongoing manner. In the initial phases, the MMs undergo four to six weeks of training by Philani outreach supervisors, where they are trained in skills relating to HIV/AIDS, maternal mental health, nutrition, basic health including tuberculosis (TB), alcohol use, knowledge about community resources and services, and information on grants, and referral routes and mechanisms. The training is experiential and interactive. Potential MMs watch videotapes of other MMs implementing the interventions, in order to highlight effective scenarios and the common challenges they might face during the home visits. Furthermore, through role-playing techniques, the MMs explore effective ways of building trust with mothers and learn how to use such trust to improve the consistency of healthy daily routines. The training also provides a space for the MMs to talk about their own life challenges and develop coping-skills in this regard.

The MMs work half-time (four hours daily), including making home visits on four days and attending supervision one day each week. They are paid R1700 a month (about $150), a stipend being offered by the government. Whilst this is not a full-time position (08:00h–13:00h), it is still significantly below what one would expect for a para-professional position within the state service for example. The supervision involves exploring the personal and professional challenges MMs may be experiencing and collaborating with the MMs to develop appropriate action plans and problem-solving strategies for their clients. In addition, twice monthly, a supervisor attends the home visits with each MM to ensure that the implementation is proceeding as planned.

Continuing support and supervision is also provided through the innovative use of mobile phones. All MMs carry mobile phones, with a specific application loaded onto it. When a mother prepares to enter a home for a visit, she enters the client's identifying information into the phone and receives a confirmatory prompt as to which pre- or postnatal session needs to be delivered. Upon exiting the home, the MM is prompted to select which of eight core intervention topics were discussed at the visit. This information is reviewed by supervisors and discussed during the weekly supervision meetings.

Providing care through an ongoing, person-centred and pragmatic problem-solving approach

Rather than case-finding from a clinic list, MMs draw their case load from a geographically defined neighbourhood. They thus visit all mothers in their assigned neighbourhood to identify those most at risk for health problems and who might not present at clinics. For those mothers who are identified as at risk, they are visited by MMs once every two weeks over two months to deliver the four antenatal sessions and once every two weeks after birth over two months to deliver the four postnatal sessions. Thereafter, the MMs check in with the mother and family about once a month to deliver support as needed. The frequency of visits is always based upon the clients' specific needs.

The home visits typically take about 20 minutes but can last up to an hour if a family has multiple stressors or is in crisis. The focus of these sessions is to improve health outcomes by identifying and addressing immediate health concerns, providing health education, affording social support and practical assistance, and ultimately working with mothers to engage in healthy practices. In addition, MMs try to prepare pregnant women emotionally and mentally for their babies. They talk with the women about the kinds of difficulties they might experience, encouraging her to think about the birthing process—for example, how she will get to the hospital and who will be there to support her. When the baby is born, mothers are provided with emotional support, with MMs encouraging them to enjoy life and their babies, take time for themselves and be receptive to help from others. MMs also share their optimism and support mothers in noticing daily joys in their children and family. The approach taken during the sessions is primarily about working together to identify, understand and address the mothers' needs and concerns. The MMs thus focus on bonding with the women, hearing and understanding their stories and working together to think about how their problems might be tackled.

Practical problem-solving is a key aspect of the sessions. Since 2002, all financially needy mothers are entitled to a R240 monthly government child grant. Accessing this grant is a complex process which is often difficult for mothers to navigate thus making uptake of grants relatively low in the country. MMs, who have been trained on 'how to work the system' for securing the grant, thus help the mothers to access the grant. They might also refer mothers to the Philani social work programme, if necessary, to help complete the paper work. Similarly, navigating the hurdles required to access clinic-based treatment and care requires problem-solving skills and knowledge of the health care system which mothers frequently do not have. For example, mothers often do not know whether a problem is severe enough to require treatment, how to get referrals to the right clinic, how long the health appointments will last and whether it will successfully address the problem. MMs thus work with mothers to acquire the necessary information and skills in order to become more equipped at using the health care system.

The intervention that is delivered is thus fundamentally person-centred and action-oriented, one which recognises that promoting health within the community requires identifying and addressing the social conditions that place pregnant women and their children at risk for ill-health.

Case Example: 'Changing Lives for the Better'

[Written by Nyameka Gxokonyeka, Assistant Coordinator of the Mentor Mothers Project, Philani Annual Report, 2012]

On our journey to saving lives, in a certain house, we met three women who were all drunk, one with a child on her back. After introducing ourselves, we had a conversation and ended up asking her if she could allow us to weigh her child. Without any argument, she took the child down from her back and we weighed the child and found it to be underweight for its age. This mother had no Identification Document book, no birth certificate, nor child support grant and had defaulted on immunisations. Although she was drunk, she was able to show us her own home and asked us to come again and visit her the next week. A mentor mother visited the home the following week and found her sober so they started talking about updating the child's immunisations. She had two more children who were also not receiving child support grants. She followed all the advice that the mentor mother gave her. She updated the immunisations, applied for an Identification Document and birth certificates and applied for three children's child support grants.

Through the mentor mother's advice, she reduced the amount of alcohol that she was drinking, hoping to stop and decided to sell sweets and chips at the local school in order to get some form of income to take care of her family. In the afternoon, she sells 'walkie-talkies'—chicken feet and beaks for stew. She doesn't have time for visiting her friends now. With the help of Philani, she has become a responsible mother who is taking pride in herself and caring for her family. She pleaded with us not to give up on people like her in the community, as there were many like her who were just drinking their lives away. Philani has made a valuable change in this family's life.

Costs, Benefits and Potential Replicability/Transferability

Philani was designed with sustainable scaling-up as a central pillar. The Philani programme fits in with the new primary health care re-engineering programme currently being implemented by the South African Department of Health. Within this system, outreach teams will be composed of a professional nurse and an average of six CHWs per 250 families. Linked to this is the fact that the stipends paid to Philani MMs are in line with those recommended by the National Department of Health and would therefore not be an additional programmatic cost.

The Philani programme has been evaluated in a rigorous cluster randomised controlled trial. Women living with HIV were more likely to complete tasks to prevent vertical transmission, use one feeding method for six months, avoid birth-related medical complications and were less likely to have stunted infants. Mothers receiving the intervention were also more likely to use condoms consistently, breastfeed exclusively for six months and were also less likely to have stunted infants (le Roux et al. 2013).

The infants of depressed pregnant women in the intervention group were significantly taller and heavier at six months of age than the infants of pregnant depressed mothers in the control group. Compared to infants of depressed intervention mothers, depressed control group mothers were significantly more likely to have infants greater than two standard deviations below the World Health Organization weight and length norms by age over the first six months of life (Tomlinson et al. 2015)

Conclusion

In this chapter, we have described how two maternal mental health projects, based in the Western Cape Province of South Africa, attempt to address the current gap in maternal mental health treatment. We have shown how both projects draw upon the global recommendation of task-shifting/sharing but ensure that this approach is shaped by the complex needs and challenges pertaining specifically to the South African context.

As touched upon in the introduction of this chapter, various concerns have been raised about the widespread international promotion of the model of deinstitutionalisation and decentralisation of mental health care, in particular its reduction to biomedical interventions, as well as its failure to take cognisance of the already overburdened primary health care settings in many LMICs. In their development and nature, both projects address and attempt to overcome these two particular concerns. Both projects operate from the principle that the provision and sustainability of quality mental health care necessitates properly ‘caring for’ those who will be delivering such services. Both projects thus place considerable attention on training and supporting the health workers themselves. Conceptualisations of training and support in both cases are, however, somewhat different to how these notions are commonly understood and operationalised within the Global Mental Health literature, where the focus tends to be on awareness-raising and knowledge acquisition (Patel et al. 2011). Both projects employ experiential and highly interactive approaches to address the emotional needs and stresses of the health workers. The focus in both cases is inherently psychosocial in its underpinnings, placing considerable attention on developing problem-solving skills and reflective practice amongst health care workers. In both projects, training is thus about providing the space for health care workers to engage with their own emotions and life challenges, to reflect upon potential power dynamics and forms of depersonalisation and to assist with the development of coping-skills in this regard. In both cases, this kind of approach was essential for reducing drop-out rates, enhancing ‘buy in’ amongst health workers and ensuring the quality of care.

At the same time, both PMHP and Philani are situated within, and promote, a holistic paradigm of care, one which transcends generic, biomedical approaches. At the heart of both projects is an understanding of illness as emerging out of an interaction of biological, cultural, psychological, social and material imperatives. Therefore, a flexible and person-centred approach is taken, whereby the type and frequency of care provided in both cases is not pre-determined but informed by each individual woman’s idiosyncratic needs and social circumstances. Both projects possess a number of features which appreciate, and attempt to enhance, the ability to successfully analyse these needs and circumstances. For example, in both projects, each woman is assigned a single counsellor/mentor. This counsellor/mentor is tasked with engaging with each woman, building trust, hearing and understanding her stories, and undertaking regular check-ups. Furthermore, in the case of PMHP, a context-specific mental health screening tool was developed, which attempts to reflect the specific socio-cultural manifestations of, and risk factors for, mental distress in South Africa. In terms of Philani Plus, a rigorous process is undertaken to select MMs drawn from local communities who have an intimate understanding of the typical socio-cultural challenges facing the women they help.

Based on each individual woman's needs, both projects also deliver a variety of psychosocial treatment modalities. Both projects provide diverse forms of individual and interpersonal counselling, and offer various kinds of social and material support which address the conditions in which women live. PMHP has established lines of referral to other services (e.g. social services, legal services, shelters, parenting support, HIV/AIDS peer support), whilst Philani health workers target multiple diseases and outcomes simultaneously, including problem-solving, signposting and practical support around social concerns. In addition, both projects employ practical problem management approaches which are geared towards promoting health and empowering service users to become active collaborators, rather than passive recipients of health care.

Both PMHP and Philani therefore draw upon the global recommendation of task-shifting but locate this practice within the South African context. Both projects attempt to speak to the multitude of complex issues that characterise the country's social fabric—issues of language, of the legacy of apartheid, of poverty, of intersecting epidemics, of service provider-user power dynamics, and of the diversity in manifestations of mental distress. Both projects are underpinned by an inherent assumption that promoting wellbeing and fostering quality care depend upon a deep and nuanced understanding of these contextual issues.

These projects thus demonstrate how, although the broad framework of task-shifting/sharing has relevance for South Africa, and indeed may be applicable for other LMICs, if this approach is to be adopted it needs to be shaped first and foremost by local needs, understandings and challenges. More specifically, such task-shifting/sharing initiatives require a theorised engagement with the complexities of race, culture, class, gender, to name a few, and how these issues may impact upon health and the provision of health care. We have demonstrated the potential transferability of aspects of both of these projects to other settings but have also alluded to various factors embedded in these projects that may not necessarily be applicable in other settings. Public health environments are varied and diverse, with each health facility presenting challenges and opportunities specific to its context. Ultimately, these projects illuminate how the messy realities in which both health care providers and users live and work need to be at the core of task-shifting/sharing initiatives rather than wished away by the potential promise of generic approaches and frameworks.

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Towards School-Based Interventions for Mental Health in Nigeria

Bolanle Ola and Olayinka Atilola

Incorporating mental health into *school health programmes* (SHPs) has been identified as an appropriate and effective strategy for *child and adolescent mental health* (CAMH) promotion and intervention in both developed and developing countries (American Academy of Pediatrics Committee on School Health 2004; Patel et al. 2007; Patel et al. 2013). This approach is particularly apt in developing countries where human and material resources for CAMH are often severely limited (Robertson et al. 2010). The school environment is however yet to be established as a formal setting for providing CAMH programmes in most developing countries, especially in sub-Saharan Africa. This assertion is corroborated by the results of systematic reviews of school-based mental health services around the globe, which highlight a dearth of studies in sub-Saharan Africa (Katz et al. 2013; Corrieri et al. 2013). Furthermore, research within the last decade from Nigeria has recommended the establishment of *school-based mental health programmes* (SBMHPs) as an innovative way of broadening and harnessing resources for CAMH services (Ibeziako et al. 2009; Bella et al. 2011).

In designing SBMHPs for a region, it is expedient to document the nature and correlates of mental health problems among school-age children, including the broader socio-political context of child mental health. This knowledge will optimise the extent to which SBMHPs are appropriate to particular

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contexts. Contentious issues such as potential risks of inappropriately assigning diagnostic labels to school children, as well as the merits and demerits of school-based programmes in general, need to also be critically examined. These critical perspectives will help to avoid common mistakes such as the unwitting stigmatisation of service users (AAP Committee on School Health 2004) and poor or de-contextualised implementation of programmes (Atkins et al. 2003; Timimi 2010).

This chapter reviews the scientific literature in order to discuss critically the aforementioned issues as they affect the feasibility of implementing SBMHPs in Nigeria. The lessons learnt from the review will help in the design of a needs-based and context-appropriate SBMHP for the region. The chapter closes with a suggested pathway to the introduction of SBMHP in Nigeria, and by extension, other developing countries with similar socio-economic, cultural and political realities.

Epidemiology of Child and Adolescent Mental Health Problems in Nigeria

Prevalence

Studies that screened for general childhood psychopathology in Nigeria have documented a prevalence rate between 15% and 19% (Abiodun 1993; Adelekan et al. 1999; Akpan et al. 2010). This falls within the range of 13–20% that has been reported for sub-Saharan Africa in systematic reviews (Cortina et al. 2012). The figures are however much higher than those from developed countries. For instance, in the BELLA study, which used a nationally representative sample in Germany, the overall prevalence estimate of childhood psychopathology was 6.6% (Ravens-Sieberer et al. 2008). A national survey of mental health problems among children and adolescents in the UK also reported a prevalence rate of 10% (Meltzer et al. 2000). These differences could be reflective of a true higher prevalence, but could also be due to the fact that the few CAMH epidemiological studies from Nigeria are limited in their representativeness and have employed relatively small sample sizes. Other factors that might have led to these results include different expectations of child behaviour norms, cultural difference in perception of psychopathology and problems with translation of instruments across cultures.

Other epidemiological studies in Nigeria have focused on the prevalence of specific childhood mental disorders like anxiety and depressive disorders, substance use and traumatic exposure/posttraumatic stress. Adewuya et al.

(2007) found a 12-month prevalence rate of 15% DSM-IV anxiety disorders among school-going adolescents in a semi-urban setting in Nigeria. This is comparable to the 18% that has been documented in Europe and North America (Essau et al. 2000; Kessler et al. 2005). Using the Patient Health Questionnaire (a non-diagnostic screening instrument), Fatiregun and Kumapayi (2014) reported a 21% prevalence rate of depressive symptoms among a cohort of school-going adolescents in Nigeria. Similarly, high prevalence rates have been reported in studies from developed countries (Patten et al. 1997; Wight et al. 2004).

Socio-Cultural and Political Context of Childhood in Nigeria

In the Nigerian studies reviewed, the most consistent risk factor associated with either the presence of general psychiatric morbidity or a specific mental health problem was problems with the individual's primary support group, including family disruption and dysfunction, and difficult socio-economic circumstances (i.e. parental unemployment and poverty) (Abiodun 1993; Adelekan et al. 1999; Akpan et al. 2010; Oladeji et al. 2011). These findings are consistent with the results of a previous systematic review of CAMH problems in sub-Saharan Africa (Cortina et al. 2012). These risk factors need to be incorporated into conceptual and theoretical frameworks as well as intervention strategies of any school-based mental health interventions in Nigeria.

There are however many important potential risk factors unexplored within the socio-cultural and political context of childhood in virtually all the epidemiological surveys of CAMH that have been conducted in the country. For instance, current social indicators for the Nigerian child are replete with poor indices of child wellbeing (UNICEF 2012). Culturally entrenched gender biases ensure that girls are put at further disadvantage. Girls in Nigeria generally fared poorer on most of the childcare indicators, including school enrolment (UNICEF 2012). Harmful traditional practices also tend to focus more on girls than boys, including female genital mutilation and forced marriage (UNICEF 2012). Distribution of food in the household also sometimes gives preference to boys over girls (Omigbodun and Olatawura 2008). The implications of these gender issues for CAMH are yet to be incorporated into epidemiological surveys of mental health problems among children in Nigeria. Epidemiological figures have been separated according to gender, but the contributory effects of issues like discriminatory treatment, genital mutilation or forced marriage on the mental health of female children in the region have not been specifically controlled for. In addition, legislative and social frameworks for the protection of children's rights in Nigeria are relatively weak, with many children being victims of abuse, maltreatment and neglect (Atilola 2013). The implications for CAMH are yet to be evaluated.

Furthermore, the Boko Haram insurgency in the country constitutes another major challenge. Accurate data on the magnitude and pattern of CAMH problems in the endemic social and humanitarian crisis that is ascribable to the insurgency of Boko Haram are yet to be documented in a systematic manner. However, it is conceivable that a large number of families would have been bereaved, traumatised, displaced and/or deprived of their source of livelihood as a result of the insurgency. Moreover, other known tactics of the sect include indoctrination of older children as 'child soldiers' and abduction of girls as sex slaves or for ransom (Maiangwa and Agbiboa 2014; Zenn and Pearson 2014). In keeping with the ideology espoused by the Boko Haram sect that 'Western education is a sin', there have been repeated attacks on schools. The circumstances associated with the activity of Boko Haram are an example of political and social crisis that may impact on child mental health in Nigeria, highlighting the need for broader initiatives at the political level alongside the provision of CAMH services to protect child mental health and wellbeing.

School-Based Mental Health Programmes

Strengths of School-Based Approach to Mental Health Programmes

SBMHPs have several advantages over other models of CAMH service like hospital-based or community-based care (Caulkins et al. 2004; Aos et al. 2004). First, SBMHPs afford the opportunity to reach a large number of children and adolescents, especially in regions with high school enrolment. Secondly, the natural barrier of service location is effectively eliminated as services are located within the same environment as potential service users. Thirdly, the proximity of service will reduce the cost and time burden of scheduled visits to external mental health services. This proximity also encourages more young people to acknowledge and seek treatment for mental health concerns (Kaplan et al. 1998). Fourthly, the familiar setting of the school environment can imbue a sense of belonging that may reduce the real or perceived stigma and intimidation that young persons and their families may feel when they go to unfamiliar and perhaps less culturally compatible mental health settings (AAP Committee on School Health 2004). By extension, this will promote not only service utilisation, but also the participation of teachers and parents.

Furthermore, in resource-constrained settings where community-based CAMH services are limited, harnessing the resourcefulness of teachers, school counsellors, school health officers, and the school environment in general (a kind of 'task-shifting') is a way of maximising resources (Padmavati 2012). In addition, schools have an opportunity to observe children in different conditions like the classroom, peer relations and extra-curricular activities. This unique opportunity facilitates identification and monitoring of the progress of interventions. Cross-cutting mental health and academic problems can also be best attended to in SBMHPs. Lastly, locating mental health programmes with social welfare services within the school can facilitate opportunities for students to feel more connected and see their school as a caring community. This connectedness has been found to have its own indirect effect on engendering behaviours that promote mental health (Blum and Ellen 2002).

Weaknesses of School-Based Approach to Mental Health Programmes

School-based mental health services also have some disadvantages. According to UNICEF's (2012) State of the World's Children, school enrolment is as low as 63% in Nigeria and similarly low in most other developing countries. Therefore, SBMHPs will first have to contend with getting more children to attend schools before it can have far-reaching impact in developing countries such as Nigeria. Out-of-school children are also likely to be at greater risk of mental health problems (McCarty et al. 2008). Receiving mental health services within the school presents its own challenges, one of which is the risk of stigmatisation by peers (AAP Committee on School Health 2004). The organisation of SBMHPs within the continuum of other health services and ensuring discretion on the part of service providers and general confidentiality can ameliorate this challenge.

Furthermore, locating health services of any kind within the school and involving teachers in its implementation present a situation of competing responsibilities. In schools, research has shown that SBMHPs are often poorly implemented (Atkins et al. 2003). One of the identified barriers is the poor buy-in of teachers (Langley et al. 2010) often related to perceived increased work burden and competing responsibilities (Forman et al. 2009). This is especially important in a setting like Nigeria where teachers are poorly motivated and overburdened with a large student-teacher ratio (Bennell and Akyeampong 2007; Tilak 2009). However, this can be addressed by clear and concise programme modules with clear role assignment (Langley et al. 2010). Buy-in can also be promoted by active engagement and general improvement in teacher motivation, including specific incentives for participation and uptake of SBMHPs.

More importantly, SBMHPs will naturally increase the volume of mental health-related discourses associated with initiatives aimed at enhancing mental health service provision and increasing mental health literacy. This will create a demand for persons with competence in mental health education and mental health service design and delivery. These developments may come with unintended effects. In a region like Nigeria (and most countries in sub-Saharan Africa) where there is rich indigenous knowledge of parenting and community childcare (Pence and Shafer 2006), the introduction of 'child mental health practitioners' within the school environment may lead to local beliefs and practices being undermined by 'expert' and globalised knowledge systems (Said 1993). This could lead to the erosion of valuable knowledge and practice such as kith and kin care, kith and kin fostering, community storytelling (as a form of enculturation, social learning and group therapy) and other local remedies for various physical and psychological disturbances in childhood.

Also, the very availability of mental health services within the school can create a situation in which children with otherwise normal variants of mood and behaviours are diverted into school mental health services. Some critics have argued that the global increase in the diagnosis and treatment of childhood mental health problems may not necessarily reflect increased incidence but a change in the way we view 'normal' childhood (Timimi and Leo 2009; Timimi 2010). This medicalising approach to child mental health may also train children to relegate or forgo their own locally derived personal agency and coping strategies in favour of 'expert' advice (Timimi and Leo 2009; Timimi 2010). The care, attention and support provided to school children, identified with mental health problems or risk, could undermine the children's confidence and sense of personal agency. This is particularly important in a setting like Nigeria where there is a high premium on personal responsibility, and the ability to overcome adversities among children and youth. These are protective factors that have been found to enhance youth mental health in Africa (Meintjes and Giese 2006).

In the same vein, an SBMHP which is not a particularly nuanced approach may create a situation whereby the complex dynamics of the school environment are interpreted by teachers solely from mental health perspectives. As such, ordinary events like ‘noise-making’, which teachers previously understood as routine infractions, may then assume a higher disruptive value in line with the medicalising approach. The introduction of SBMHPs and the professionalisation and specialisation of skills for management of emotional and behavioural issues within a mental health framework might undermine teachers’ existing confidence and skills in dealing with these issues and with the day-to-day complexities of the school environment (Timimi and Leo 2009; Timimi 2010).

School-Based Mental Health Programmes in Nigeria: Issues, Opportunities and Strategies

Issue 1: Lack of Mental Health Components in School-Based Health Programmes in Nigeria

The current National School Health Policy of Nigeria (Federal Ministry of Health 2006) has five sections: ‘healthful school environment’, school feeding services, skills-based health education, school health services and school–community relationships. Scrutiny of the policy reveals the lack of a framework for mental health. For instance, the stated objective of the policy’s ‘healthful school environment’ is exclusively focused on maintaining a physically safe and hygienic school environment. There is no mention in the policy of any strategy to address situations like physical violence, psychological violence (e.g. bullying, intimidation, victimisation), sexual violence/harassment and/or gender-based violence, which can constitute mental health risks.

The section on school health services shows similar omissions. The stated objective of the policy’s school health services is to:

> provide basic services for disease prevention and management of injuries in the school [and to…] build capacity of the school community to identify, treat, and manage simple illnesses, injuries, infections and infestations. (Federal Ministry of Health 2006, p. 12)

The objective and the implementation guideline have no clear direction for addressing child mental health issues.

The stated objective of the section on ‘skills-based health education’ is to promote the development of sound health knowledge, attitudes, skills and practices among the learners, which is to be achieved through skills-based health education curricula for schools. While these stated objectives could be expanded to include mental health, an ongoing review of the national school health curricula for students in Nigeria showed deficient mental health content (Atilola et al., in preparation). Curricula focus largely on physical and environmental health with scant mental health content. Recognition and prevention of substance abuse was overwhelmingly the main thrust of mental health education in the curricula. Help-seeking options, effective self-help strategies and first-aid skills for mental health problems were not addressed in the curricula.

One of the closest things to mental health service provision within school-based health programmes in Nigeria today is the creation of school counsellors (Federal Government of Nigeria 2004). These are diploma or graduate degree holders from faculties or colleges of education in the country, and their duties broadly include academic advice and providing counselling services. Several studies conducted in Nigeria have documented that school-based guidance and counselling services in Nigeria are challenged in the area of poor conceptual framework (Mogbo 2005; Odoemalam and Uwam 2009), severe human resource constraints (Alao 2009; Nwokolo et al. 2010) and uncertainties about the usefulness and relevance of the training curricula (Alika 2012).

The special education service is another area with some presence within the current framework for SBMHPs in Nigeria. The country has one institution dedicated solely for the training of special education teachers. The school awards diplomas in various aspects of special education such as education of the visually impaired, the hearing impaired and the learning disabled. Mental health literacy and knowledge of basic child mental health problems are not included in their curriculum. This is despite the fact that childhood disabilities are key risk factors for CAMH (Witt et al. 2003). There are also a number of public and private schools where exclusive special education is provided for children with disabilities. Inclusive learning support for children with disabilities within mainstream schools is however not yet a popular approach in Nigeria.

Issue 2: De-Contextualised Needs Assessment as the Foundation of SBMHPs in Nigeria

In a country like Nigeria, which is attempting to establish a formal SBMHP, baseline data and needs assessment on resources and capacity can be a strategic first step (Walter et al. 2006). Our review of the Nigerian literature has revealed that such data focusing on the currently available human and material resources for a successful SBMHP in Nigeria are being gathered. However, generally speaking, needs assessments are not properly contextualised to ensure that the resulting recommendations will engender an SBMHP that is culturally nuanced and contextually relevant.

For instance, recent needs assessments have concluded that the baseline knowledge of teachers and students about mental disorders was poor and that there was a need to educate them properly about mental disorders (Ibeziako et al. 2009; Dogra et al. 2012). The conclusions of these studies were based on the assumptions that the nosology and explanatory models of mental disorders are universal and not influenced by local understanding and knowledge about distress. Similarly, other needs assessment have concluded that school teachers were unfamiliar with mental health constructs based on their limited ability to label orthodox psychiatric constructs 'correctly' (Bella et al. 2011). The findings from these needs assessments are but one epistemological perspective, and if these findings are given priority over other perspectives, there is the tendency to assume that until the views of teachers and students are aligned with Western concepts about mental disorders, SBMHPs will not be a success. Furthermore, based on these assumptions, a lot of energy and resources may be expended first trying to align teachers' and students' views with Western concepts of mental health and ill health, thereby ending up with a completely de-contextualised programme. It will probably be more useful to gain more insights into how mental health is understood in this region through qualitative narratives and to build on such understandings to complement other perspectives.

The methodology of the needs assessments might also fail to reveal the nature of CAMH problems in Nigeria. We noted that most of the baseline data on the prevalence of mental health problems among school-going children and adolescents in Nigeria (Abiodun 1993; Adelekan et al. 1999; Adewuya and Famuyiwa 2007; Akpan et al. 2010) were gathered using quantitative self-report instruments (e.g. the Rutter's Behaviour Scale Reporting Questionnaire for Children) whose cultural validity is yet to be firmly established. Qualitative research with due consideration for personal narratives about the unique experience of mental illness for children in this region are needed within the bio-psychosocial framework. In addition, the possibility of child mental disorders that are distinct to particular cultural settings (Canino and Alegria 2008) dictates that such surveys incorporate items to assess syndromes that have been identified by local orthodox mental health practitioners as well as those which may have been identified by traditional and faith healers but that do not form part of any orthodox psychiatric nosology (Canino and Alegria 2008). For instance, brain fag syndrome—a culture-bound syndrome of psychological distress related to studying—has been described among school-going adolescents in Nigeria (Prince 1962; Ola et al. 2009). It is possible that there are other culture-bound symptomatologies among school-age children which have been observed but have yet to be reported.

Similarly, there are distinct resilience-enhancing resources, which could be an important component of mental health promotion in SBMHPs. For maximal benefit, there is need to contextualise such resilience-enhancing strategies (Betancourt et al. 2011). As a resilience-enhancing resource, there are well-established links between spirituality and the mental health of children (Doolittle and Farrell 2004; Bonab and Hakimirad 2010), and Africans are known to have deep spiritual inclinations (Mbiti 1989). The potential role of spirituality as a distinct component of wellbeing among children and adolescents (Houskamp et al. 2004) is yet to be evaluated in Nigeria.

In addition, faith-based organisations remain a community-based resource that provides various forms of spiritual services in many African settings (Kaplan et al. 2006). Spiritual counsellors provide spiritual guidance, which can promote resilience, while spiritual healers provide alternative therapies, which are often in sync with the views of community dwellers about mental disorders. Aside from the extensive geographic reach of these organisations, the services are usually more accepted by parents and caregivers (Abdulmalik and Sale 2012; Bakare 2013). Faith-based organisations are therefore a potential culturally relevant community-based resource for SBMHPs in Nigeria, and their early involvement will not only bring their perspectives to the fore but also engender their genuine cooperation. The involvement of the faith-based organisations in other CAMH programmes has been reported to have enhanced the acceptability of the initiative and enabled resource sharing, holistic care (physical, mental and spiritual), cultural sensitivity and continuity of care (Bella et al. Unpublished). Conflicts however arose in the area of explanatory models and treatment modalities as some of the service users were labelled and treated as witches. Finding a point of compromise, ensuring that any form of treatment will adhere to the tenets of human rights and avoid stigma and setting clear terms of collaboration from the outset can help improve the effectiveness and feasibility of programmes.

Opportunities and Strategies

Contextualised School-Based Mental Health Policy from the Outset

As reviewed, SBMHPs in Nigeria are still in the development phase. The bright side of this unsettling situation is that Nigeria has an opportunity to develop an SBMHP from scratch, drawing on the strengths of school-based approaches to mental health services while being cognizant of the inherent weaknesses of such programmes. Nigeria could take a lead in evolving a model SBMHP that may serve as reference point for many sub-Saharan African countries, which are at similar level of development with Nigeria and with a similar socio-cultural milieu. There has been a growing critique of globalised approaches to scaling up mental health services in developing countries where several unique social, economic and cultural factors contend with and confound mental health (Brhlikova et al. 2011; Das and Rao 2012). Focus on curative or restorative approaches to mental health as a strategy to bridge mental health gaps in low- and middle-income countries (LMIC) has been described as 'insufficient and narrow' (Campbell and Burgess 2012). It has been argued that mental health and disorders are dictated by social circumstances as much as they are by personal vulnerabilities (Skovdal 2012) underscoring the need for mental health policies that take into consideration the social-cultural, economic and political realities of LMIC.

Therefore, one of the strategies for a context-relevant SBMHP for Nigeria is to evolve an appropriate school-based mental health policy for the country, which can set the tone and direction for the programme from the outset. Rather than relying on policy suggestions from developed countries that may be de-contextualised, policy advisers in Nigeria should evolve a school-based CAMH policy for the region taking cognizance of local realities and tapping on local experience and expertise. Doing this will require an understanding of the unique ecology of the school environment in Nigeria. In other words, there is a need for theoretical frameworks to capture the full ramification of the school environment in Nigeria, from which multilevel, context-appropriate and holistic school-based mental health policy directions can be understood (Atilola 2014). For instance, based on an ecological model of CAMH in Nigeria, Atilola (2014) recommended that strategies that promote resilience such as child-sensitive social protection for vulnerable families and improved access to childcare resources should be the thrust of CAMH policies in the region.

Drawing on such perspectives, CAMH policy in Nigeria needs to prioritise strategies to promote the mental health and resilience of children from the community in the first instance, enhance the capacity of the school environment to build resilience and provide complementary mental health services. Building the mental health and resilience of children within the community will entail ensuring they have access to early childcare resources (i.e. good nutrition, immunisation and quality parenting), including opportunities to access school. It will also involve rallying the community to secure their support for and buy-in into SBMHPs. Invigorating the school environment to support mental health will include provision of a safe environment and promoting the resilience of school children through promotion of self-efficacy, personal agency, spirituality, religious and social engagement, and any other resilience-enhancing activities as may be suggested by future local research.

Enrolling and Retaining Children in School

In the context of Nigeria and other sub-Saharan African countries where school enrolment is still low (UNICEF 2012), a major step in a comprehensive school-based mental health policy will be to get the children to attend school in the first place. In Nigeria, up to about 4% of 6- to 11-year-olds do not attend any primary school (Nigeria Demographic and Health Survey 2011). The poorest households in Nigeria also have the lowest school enrolment rates (UNICEF 2012). This situation has potential for further excluding the most vulnerable children from SBMHPs, with attendant risk of further reinforcing inequalities. Though data are not yet available, school enrolment is presumably worse than before in Nigeria at this time with the onset of armed conflicts, such as the Boko Haram insurgency, which disrupt or target schools.

Therefore, a holistic SBMHP in Nigeria must, as a matter of necessity, incorporate strategies to mitigate factors that serve as barriers to children accessing schools in the first instance. This will ensure that when SBMHPs are put in place, no child is excluded from benefiting from it. Such strategies will include broader community-based interventions to support vulnerable children and initiatives outside of the school. Social protection schemes like conditional cash transfers can mitigate the social and economic challenges that affect the capacity of poor and vulnerable families to get their children into schools. The conditionality in this case can include accessing childcare resources like immunisation, good nutrition, compulsory growth monitoring, attendance at family counselling and compulsory school attendance.

To retain children in school, regions like Nigeria where there are ongoing armed conflicts and attacks on schools will also have to evolve programmes to protect children in school or on the way to school. This is why programmes such as the *Safe Schools Initiative* currently being piloted in northern Nigeria are important. The initiative aims to create a security system whereby school children are protected on their way to and from the school. In addition, a security system is developed to protect school premises and respond swiftly to security threats. A rapid response system to quickly repair or rebuild schools and to provide psychosocial first-aid is also in place, in case of an attack.

School-Based Promotive and Preventive Mental Health Programmes

SBMHPs need to have components to promote the mental health of children and to detect problems early. This includes the need for school health education curricula with adequate skills-based mental health content. Akin to this is the incorporation of extra-curricular life skills training into schools. The importance of the personal agency of young persons in building resilience in the face of adversity has recently been further established in research (Bonanno and Diminich 2013; Ungar et al. 2013, Tol et al. 2013). This new paradigm has led to calls in Africa for youth mental health programmes focused on building children's ability to cope with moderate adversity with minimal psychological impact (Skovdal 2012). There is a need for a shift in focus from strategies aimed at addressing the perceived mental health challenges of children, to those aimed at adapting the school environment to promote resilience and mental wellbeing.

There is a growing body of evidence that life skills training has demonstrable benefits in promoting resilience and engendering good mental health among young persons (Polan et al. 2013; Ager 2013). Some workers in Nigeria have suggested that school counsellors should incorporate life skills training into the school curriculum as a way of promoting youth resilience and wellbeing (Akpan 2009). This is in line with international best practices (Bandura 1995; Jennings and Greenberg 2009). A qualitative study conducted among youth in Uganda identified specific resilience-enhancing life skills, which assisted youth to cope with adversity (Betancourt et al. 2011). However, the identified skills were significantly different from those identified in the Western literature (St Leger et al. 2010; Barry et al. 2013; Busch et al. 2013). Therefore, it appears that life skills that promote resilience are context sensitive. Use of predetermined de-contextualised parameters of resilience will therefore translate to designing resilience-focused interventions that are not maximally relevant to the culture and setting (Tol et al. 2013). These arguments are consistent with earlier reflections on cross-cultural variability in what promotes resilience (Ungar 2008). These considerations should guide the development of resilience-building programmes in Nigerian schools.

Early identification is a critical component of the preventive aspect of SBMHPs. Mental health screening can also be incorporated into the regular school health screening to ensure early detection of problems and drawing up an intervention plan. Furthermore, child maltreatment and abuse are common but hidden issues across the globe, especially in developing countries

(UNICEF 2010), and it has important consequences for child mental health. This is one area that teachers need to be able to detect and address. The initial challenge for school-based detection of child maltreatment was the high variability in legal and conceptual definitions of the phenomenon across regions (Ashton 2010). Recent works have however developed measures, which are psychometrically sound and culturally relevant to the Nigerian setting (Fakunmoju and Bammeke 2013). The availability of such instruments provides a unique opportunity to sensitise teachers, in a culturally appropriate way, to have high index of suspicion for and accurate detection of child maltreatment among school children. A confidential maltreatment reporting mechanism can also be incorporated into the SBMHP and students should be made aware of such mechanisms.

Children identified as maltreated and those in which some behavioural or emotional difficulties are suspected can then be referred to the school Guidance and Counselling Unit. Short and structured instruments that can be used to further screen for mental and behavioural problems are also available (i.e. Strengths and Difficulties Questionnaire, Short Mood and Feelings Questionnaire, Child Behaviour Checklist) but need to be culturally adapted. It should be noted that while in some cases legal action or some form of mediation is necessary to protect the child from further abuse, priority should however be placed on identifying and tackling the source of abuse. Adopting this problem-solving approach will not only reduce stigma but also likely to receive more acceptance.

School-Based Restorative Mental Health Services

Despite promotion- and prevention-focused mental health programmes, a few children will still need restorative interventions. Very recently, some studies have started to evaluate, on a rather small scale, school-based psychological interventions for common emotional and behavioural problems in Nigeria. Abdulmalik (2014) found that a two-week group-based problem-solving psychological intervention produced significant symptom reduction in symptoms (Cohen's effect size: 1.2) among a cohort of primary school pupils in Ibadan, Nigeria. Similarly, Bella-Awusah (2014) also found a significant symptom reduction among depressed children and adolescents after a behavioural/problem-solving intervention. A key finding in these studies is the high level of satisfaction with the intervention but a preference for the service being provided by school personnel outside the school premises. This preference was borne out of wish for privacy and less interference with schoolwork.

School psychologists, social workers and guidance counsellors can be trained to provide behavioural and psychological interventions after school hours. In line with Foster et al. (2005), the school district can also establish a linkage with existing child mental health services in the community where mental health professionals and school personnel can provide further service and share resources. This will engender more collaborations between school-based and community mental health service providers. Collaborative- school and community-based child mental health and social services are being adopted in some African countries like Tunisia and Egypt where SBMHPs are gradually taking hold (Gaddour 2007).

Situating SBMHPs Within Existing Framework for SHPs

SHPs are gradually being established and taking hold in Nigeria. Therefore, rather than embark on any ambitious effort at establishing a parallel SBMHP, a key strategy for a sustainable programme in Nigeria is to situate the SBMHP within the current existing framework for SHPs in the country. Because of the potential obscurity of child mental health issues in this region (Omigbodun 2009), it is important to situate child mental health initiatives within the general focus of school child health policy. This will ensure that the programmes grow together. In developing countries like Nigeria, it has been recommended that all child-focused programmes be intercalated to ensure resource sharing (Lund et al. 2008). Therefore, we recommend an approach in which mental health components are incorporated into all the components of SHPs in Nigeria.

Conclusion

The current lack of structured school-based mental health services in Nigeria, though disheartening, presents an opportunity for the bottom-up creation and integration of a programme with the highest potential for relevance and impact. To ensure resource sharing and enhanced visibility, the programme should be situated within the current framework for school-based health programmes in Nigeria. Needs assessments are vital to ensure cultural contextualisation of programmes, and to enhance acceptability, relevance and impact. Personal and communal resilience-enhancing interventions and engagement with community-based resources, especially faith-based organisations, should be the general direction of programme.

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25

A Family-Based Intervention for People with a Psychotic Disorder in Nicaragua

Rimke van der Geest

> When researching the experiences of families with a psychotic family member in Matagalpa, a town in the central highlands of Nicaragua, I encountered most of my research participants by word of mouth. Talking about the topic, people often mentioned they knew someone who was 'loco' (crazy). One day, I was told about two brothers who talked to themselves. They lived in a small shabby house with their elderly mother. As usual, I decided to visit. A man with a beard sat grinning on the doorstep. He introduced himself to me as José[1] and started telling me about his brother Matías who was not doing well. I asked him whether I could introduce myself to him. José said I could but it was dangerous to enter the house because Matías might hit me. Than the mother appeared. 'Come inside', she said. She offered me a chair and we all sat down. Behind a small wall, I saw Matías lying on the floor; extremely skinny, dirty and wearing only ripped and worn pants. Around him were pieces of fabric, paper and plastic, some of them squashed together as a pillow. He ignored us and mumbled busily to the voices in his head. María apologised and said it was his own decision to lie on the floor.[2]

The author of this chapter, who works as a psychiatric nurse in the Netherlands, has been visiting Nicaraguan families with a psychotic member over a period

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[1] All names of patients and family members in this chapter are pseudonyms.

[2] The case material in this chapter is partly derived from Van der Geest (2011).

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of ten years, first in the context of anthropological fieldwork, later through setting up and working with 'Cuenta Conmigo' (CC), a non-profit organisation that organises psycho-education and peer support for people with a psychotic disorder and their families in Matagalpa. She argues that by solely focusing on clinical management of individuals, there is a risk that valuable energy and money are wasted—patients continue to relapse or do not stabilise at all. While antipsychotic drugs can be effective and cost-effective for the treatment of psychotic disorders, their benefits can be enhanced by psychosocial interventions, such as community-based family support and education (Patel et al. 2007, p. 991). By describing the working method of CC, an attempt is made to show that in a context of poverty and limited psychiatric care, it is possible to improve the lives of psychotic patients and their families with only a minimum of resources.

This chapter will describe the national mental health system in Nicaragua, before focusing on the town of Matagalpa. It considers what people do when their family members develop a psychotic disorder and what type of care is available. The author will then explain how the non-profit organisation CC has emerged and how it evolved into the organisation it is today. The chapter concludes with a discussion on the strengths, limitations and challenges of CC's approach.

The Mental Health System in Nicaragua

Nicaragua (population of six million) is the second poorest country in Latin America after Haiti. Although poverty has declined in recent years, natural disasters and distortion of commodity prices in the international market have led to increased poverty in rural areas (World Bank 2014; IFAD 2014). The healthcare system of Nicaragua is divided into public and private care. Less than 1% of the national health budget is used for mental health care and 91% of this is used for the only psychiatric hospital in the country in the capital Managua. Psychiatric and/or psychological consultations are offered in 34 of the 177 public health centres. There are around 92 psychiatrists in the country. The majority (80%) work in the capital, mostly in private clinics. Since the 1990s, specialists have opened private practices because of scarce job opportunities and low salaries in public mental health services, and many psychiatrists emigrate within five years of completing their training. Only 2% of medical education is devoted to mental health; consequently, medical doctors have little knowledge about psychotic disorders. Psychiatric nurses do not exist in Nicaragua. The nurses who work in the psychiatric hospital in

Managua do not receive specialised education in psychiatry (Informe de Pais Republica de Nicaragua 2005; Van der Geest 2011; WHO 2011).

No exact data exist on the treatment gap for people with a psychotic disorder in Nicaragua. A review of epidemiological studies conducted between 1980 and 2004 estimated that in Latin America and the Caribbean, over one-third do not receive care (Kohn et al. 2005). For those that do get help, the care is not very effective. Free medication in Nicaragua is limited to cheaper first-generation antipsychotics like haloperidol, thioridazine and chlorpromazine. Despite their inclusion on the Ministry of Health's basic medicines list, the supply is insufficient and availability varies from month to month. All this causes frequent discontinuation of and changes in treatment.

Given the unequal spread of psychiatrists in the country, for many Nicaraguans there is no psychiatrist nearby. To receive medication, patients and family members have to travel to the nearest town. Crisis patients are referred to the psychiatric hospital in the capital, Managua. The family has to pay for an ambulance or arrange their own transport. The hospital consists of four wards with 196 beds in total. The beds have no sheets, and there is no possibility for patients to store private belongings. The average stay is over two months, and there are 73 patients who have been in the hospital for more than ten years. With one nurse and one assistant in charge of 50 patients, there is little time for individual attention. Nurses are poorly motivated due to low wages and lack of specialised mental health training. Stories of violence and patients beating each other up are common (Informe de Pais Republica de Nicaragua 2005; Van der Geest 2011; WHO 2011).

An official mental health policy does not exist in Nicaragua. In 2005, a report on the current state of mental health services in Nicaragua was published by order of the Pan American Health Organization/World Health Organization. It aimed to improve mental health care by creating a baseline for monitoring the progress in implementing new policies and developing community services. One of its recommendations was 'to involve patients, families and other stakeholders in the promotion, prevention, treatment and rehabilitation of mental health' (Informe de Pais Republica de Nicaragua 2005). However, in this respect, nothing much has happened. In 2009, there was an attempt by private persons to bring together policy makers and family members, but the initiative stopped as there was no money to facilitate the meetings, or to pay the transport to Managua where the meetings were held. As in many other low-income countries, scarce financial resources and the low position of mental health on the political agenda are two of the barriers to improvement of mental health care in Nicaragua (Saraceno et al. 2007, p. 3).

Psychosis in Matagalpa: 'It Is Better to Leave Him Alone'

One of Nicaragua's regions is the coffee-dependent central region where the town of Matagalpa is situated. This region is home to 23% of the Nicaraguan population, and 46% of the country's poorest inhabitants (IFAD 2014). Consequently, having a psychotic family member in Matagalpa is often but one problem on top of several other difficulties:

> The small house of María and her ill sons José and Matías, looked neglected; floor, walls and ceiling were full of cracks. The electricity had been cut off eight years ago because of unpaid bills. María only made a little bit of money from selling second-hand clothing in the street. The father of José and Matías passed away when the brothers were three months and three years old, respectively. He was shot in his taxi by a customer who refused to pay his fare. María had four more children with a second husband, three of whom died shortly after birth. The fourth child died six years ago at the age of twenty-four in a fight on a coffee plantation. Her second husband was a violent man, María does not want to talk about him.

When someone develops a psychotic disorder in Matagalpa, most people initially spend the little money they have on *curanderas* (natural healers) or *brujos* (witch doctors). Such healers can be far away from the homes of those who consult them. Julio, the father of a psychotic young man in Matagalpa, travelled eight hours by bus to get to a recommended *curandera* who said that he and his son had to stay for a couple of months to be able to cure the disease. Julio decided not to stay. He could not afford to lose his job in Matagalpa as he had a family to feed. Sometimes, psychotic symptoms are explained by beliefs in satanic forces. Matagalpa has hundreds of churches, mostly evangelical, and some families decide to trust only God. They pray and invite faith healers to exorcise the evil spirits.

Eventually, some families find their way to the psychiatrist in Matagalpa. Dr Espinoza[3] started studying psychiatry after the revolution in the early 1980s and has been working in Matagalpa ever since. He is available for consultations at the public clinic for an average of 45 minutes per day. Treatment consists of prescribing medication and/or referring patients to the psychiatric hospital in Managua. There is no time to explain about the origins of symptoms, the management of medication or possible side effects. Dr Espinoza

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[3] This name is a pseudonym.

does not keep medical records; he only writes down the patient's sex and age, asks which medication the patient is on and writes a prescription based on the information the family gives him. The patient is often left at home. This field note illustrates the brevity of such consultations:

> There is a queue of about thirty people in front of a door with the word 'psychiatry' written on it. When Dr Espinoza arrives, a nurse urges everyone to make room and stop pushing. It is 1.45 pm when the first patient is allowed to enter the consultation room. The patient tells the doctor that she cannot sleep at night. Her neighbour who accompanies her adds that she hears voices and sees things. The doctor asks whether she has been taking her medication. She says she has not been taking it for a while because the clinic had run out and it is too expensive to buy from the pharmacy. The next patient who comes in starts telling a story but unfortunately there is no time for it as the queue of waiting patients is long. The doctor hands her a prescription and she willingly leaves the room. Next is the mother of a woman who was found walking naked through the streets of Matagalpa a month ago. She is doing better after a recent stay at the psychiatric hospital in Managua. Dr Espinoza gives her a new prescription and calls the next patient in. He will see patient after patient until the last patient leaves at 2:30 pm. He has seen 15 patients in 45 minutes, an average of three minutes per consultation.

The conditions under which Dr Espinoza carries out his consultations are not favourable for the patients and their families. He refers to his work in the public clinic as charity work because his salary is so low. He works a couple of hours a day in a private clinic in addition to his job as a government official. In 2014, a consultation in the private clinic cost 25 US dollars, a price only the rich can afford, although poor people do get themselves into debt trying to get the best care for their loved one. The psychiatrist says his work is demanding with a lot of responsibility:

> If a psychotic patient injures someone, people will blame me.

The dosage of the antipsychotic drugs he prescribes is much higher than recommended in the guidelines. As a result, people get so many side effects that they often stop taking the medication.[4] In recent years, second-generation antipsychotic drugs have been introduced to the Nicaraguan market, but these very expensive drugs can only be purchased from private pharmacies.

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[4] Side effects of first-generation antipsychotic drugs such as chlorpromazine are common and disabling and include tremor, restlessness and muscle stiffness.

In 2009, a second psychiatrist was hired in Matagalpa to work some hours in the general hospital. Aside from the consultations in the hospital and the public clinic, there is no professional help available to monitor any medical treatment. The entire burden falls upon the family. They have to manage the patient's behaviour and make sure that he or she takes the medication. Besides the problem of side effects, the patient often stops taking pills because of lack of insight into the illness, typical of psychotic disorders. It makes families feel frustrated and hopeless. Sometimes, family members themselves stop giving medication because they think treatment can be stopped once the psychotic symptoms have disappeared. Given the brevity of mental health consultations and lack of follow-up, it is unsurprising that they have this view. As a result, patients relapse and problems start all over again.

> According to María, Matías had not been taking any medication in ten years. She said he suffered from severe side effects whenever he took it. He had been admitted to the psychiatric hospital in Managua three times. María thought he was more rebellious than José, who had only been admitted once. Despite the admissions to the psychiatric hospital both sons remained ill. María said she could not afford to continue the search for a cure. In her opinion the only option left for her was praying to God; only He might be able to change the situation.

After years of struggling with a psychotic family member, families in Matagalpa often choose to 'dejarlo tranquilo' (leave him in peace). They get to the point where they say: Let him do what he wants, do not argue with him, just accept that he cannot work or marry. The family of Camilo, a man who is—to this day—wandering the streets in Matagalpa, brought him to the psychiatric hospital seven times. According to his sister, Camilo had become ill after a doctor falsely informed him that he had HIV. He never recovered from this *susto* (shock) and has been talking to himself ever since.[5] Each time he was discharged from hospital, Camilo was less psychotic but then stopped taking medication and fell ill again. 'Now, we gave up', his sister explained. 'This must be what he wants'.

Other families choose to lock up their psychotic family member for that person's protection. The 25-year-old psychotic girl Mirna used to run away from home and return without any clothes. Her parents locked her

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[5] The explanations family members give for the change in their loved one are often formulated in a way that reduces social stigma. By naming external causes, like *susto* or hitting the head as a child, families are able to keep their dignity and social prestige (Van der Geest 2011).

up to protect her from being raped. The girl's psychiatric situation worsened dramatically due to the captivity, but the family did not see other options. In 2006, Mirna escaped and jumped off a bridge. She survived, but in 2007 she died of perforated intestines after swallowing metal nails she had pulled out the walls of her room.

Fear of stigmatisation is another reason to 'hide' a psychotic family member from the outside world. Many Nicaraguans are convinced that all 'crazy' people are dangerous. If a psychotic person injures or murders someone, it will most likely reach the front page of the newspaper. This perpetuates the image of the mentally ill as violent and feeds a popular appetite for drama. Manuel, a psychotic young man in Matagalpa, injured eight people in 2007. His mother was invited by a national television show to tell the story. She was not happy about doing so, but she was poor and they paid her well.

From Research to Action

The focus of my 2004 master's thesis in anthropology was the impact of psychosis on families in Nicaragua. How do people deal with a psychotic family member in the context of poverty? Where do they search for help when information and professional care are not readily available? I did not disclose my background as a psychiatric nurse during the research, so as to encourage families to communicate openly about visits to traditional healers and the explanations they held for psychosis. One day, however, I stepped out of my role as a researcher. It was the extreme suffering of an elderly couple that led me to move from research to action. The couple was struggling with their son, for whom they had spent years trying to find appropriate care to no avail. On top of that, they carried the burden of the tragic deaths of four of their other children. I told the father about the psychiatrist and he decided to visit. Dr Espinoza diagnosed the son with schizophrenia and prescribed medication. In the following months, the son got more stable and I gave the family information about the illness to help them understand what he was going through and that he was not the only person with this problem. This specific case ultimately led to the idea of founding a family-based intervention for people with a psychotic disorder in Matagalpa. In this town, where the burden of care came entirely down on families, it was hypothesised that providing family support and face-to-face psycho-education would facilitate more stability for the patient and therefore a better quality of life for the family as a whole.

The efficacy of family support in combination with education has been demonstrated in several studies worldwide. In high-income countries, it is shown that a combination of family support and education can lead to greater adherence to therapy, fewer relapses and fewer hospitalisations (Pitschel-Walz et al. 2001; Dixon et al. 2001). Research in Chile showed that caregiver burden[6] decreased significantly after taking part in a family intervention programme, especially in caregivers who had not previously received information about the illness (Gutiérez-Maldonado and Caqueo-Urízar 2007, pp. 739–747). Also, there is increasing evidence that family-based care is more cost-effective than institutional care (Saraceno et al. 2007, p. 4; Patel et al. 2007, p. 1000). Although there have been very few attempts to introduce family-oriented care in low-income settings, including Latin America, it seemed a feasible approach for Nicaragua where the mental health system is poorly developed and trained personnel is scarce. A study in a poor urban community in South Africa with limited access to mental health services describes the positive outcome of an intervention with four multi-family groups (Asmal et al. 2014), and another study, carried out in one of the poorest areas of India, compared community-based rehabilitation (CBR) with standard outpatient care and found that outcomes were markedly better in the CBR group (Chatterjee et al. 2003). A study in northern Ghana, where only a handful of community psychiatric nurses provide biomedical treatments, showed some evidence that the organisation of mental health self-help groups (SHGs) had positive effects on patients and caregivers. Social inclusion increased and outcomes of those who were ill improved because of more consistent treatment (Cohen et al. 2012, pp. 6–7). The SHGs in northern Ghana were organised by BasicNeeds, the largest non-governmental organisation (NGO) working in this field. BasicNeeds (see Underhill et al. in this volume) works with governments to build a sustainable community-based mental healthcare system in African and Asian countries, but to date does not work in Latin America. Their mission is to enable people with mental illness (or epilepsy) and their families to live and work successfully in their communities. The NGO has a broad-based approach combining health, socio-economic and community-orientated solutions with changes in policy, practice and resource allocation (*BasicNeeds* 2015). By employing a similar approach and bringing together families I had met in the context of my research, it was hoped that a start could be made to change the present situation in Matagalpa.

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[6] The demands of caregiving include paying for psychiatric treatment, supervising the patient, dealing with the social stigma associated with mental illness and coping with the emotional distress that the symptoms of the disorder may cause.

The Start-up of Cuenta Conmigo

Stedenband Tilburg-Matagalpa, a Dutch NGO working on issues of sustainable social development and located in Tilburg, the twin town of Matagalpa, was interested to help develop the idea of a family-based intervention for people with a psychotic disorder. Together with Comité Mano Vuelta, their partner organisation in Matagalpa, we prepared a plan in which the short-term goal was described as follows: uniting families and friends of people with a psychotic disorder and helping them set up a support group. A total of 5000 US dollars was raised by the NGO to cover initial set-up costs such as transport, office expenses, snacks and drinks for meetings and legal fees.

In 2005, I returned to Nicaragua and met the partner organisation. They provided me with a working space within their office and I started to look for motivated family members to cooperate in the project. One suitable colleague was found with the help of the psychiatrist Dr Espinoza. He referred me to Rosalba as a remarkable person since, unlike many other relatives attending his clinic, she always asked him questions about her son's illness. Her active interest was notable, since in Nicaragua it is quite unusual to speak up to someone of high status. Rosalba liked the idea of forming a support group and offered to volunteer in the initial stages. Together we started to visit families in their homes. Most families felt honoured by our visit. Many of them had not received visitors for a long time due to having a psychotic family member in the house. During visits, Rosalba talked about her experiences as a mother and caregiver. Sharing the same problem and culture, she put the families at ease and encouraged them to talk about their experiences too. Sometimes Rosalba felt uncomfortable with a patient, since she was also influenced by stigmatising ideas about the mentally ill being violent. Her fear disappeared over time as she learned more about the origins of psychotic symptoms and how these influence behaviour. At the beginning, it was one of my main tasks to provide education on these topics. In subsequent years, Spanish-speaking Dutch psychiatric nurses were recruited to volunteer in Matagalpa to take on this role.

After a while, we started to invite family members to share their experiences in a group. During these meetings, there were feelings of recognition and relief, but there appeared to be a great need for information too. We started to develop informative workshops about psychosis, medication and how to deal with difficult behaviour and problems with communication. Over time, families started reporting that the atmosphere in their home was improving and that patients were doing better. Building on this progress, we started to organise activities in which both patients and relatives participated. These meetings were meant to reduce stigma and prejudice and to show families what their ill relative was still capable of. Patients and family members played games, painted, danced and became friends with each other.

> Initially, María reacted with scepticism when she was invited to attend a meeting for family members of people with a psychotic disorder. She did not understand how this could help her, all she needed was money. When she was told that she could just attend and listen, she agreed to go. María discovered she was not the only mother with children that heard voices. She started enjoying life again. The visits from CC workers especially helped cheer up José. Years had gone by without anyone visiting their little house, and now he played the cheerful host whenever someone from CC came to visit. Every time he attended one of the family and patient meetings, he wore his shiny purple shirt. For the first time in six years José participated in activities outside his home.

To this day, it is the leisure activities of CC that are appreciated the most. Rosalba and other family members say it reflects the misery families in Nicaragua live with where there is little possibility for poor people to do something fun outside the home.

Development of Cuenta Conmigo

To secure the project, the NGO decided on paying a salary to Rosalba. As the day of my departure approached, I encouraged her and the other family members to take ownership of the project and make their own decisions. They decided on the name ‘Cuenta Conmigo’, meaning ‘You can count on me’. A more detailed project plan was made and CC’s general goal became: ‘A better quality of life for patients suffering from psychotic disorders and their families’. The term ‘psychotic disorder’ was deliberately chosen over schizophrenia to be able to include other psychotic illnesses, but also to minimise stigmatisation. The specific objectives to accomplish this goal were the following:

- Organising a space where patients with psychotic disorders and their families can express their needs and experiences to learn from each other;
- Organising psycho-educational gatherings so families can acquire skills to take care of their ill relative and of themselves;
- Providing face-to-face psycho-education and emotional support in the homes of patients and their families;

- Sensitising the community of Matagalpa and health authorities to the problems of patients with psychotic disorders and their families;
- Taking steps to work in collaboration with health professionals and other organisations;
- Lobbying the government for better care for patients with psychotic disorders.

The last two objectives were important. It was not CC's responsibility to *treat* patients. However, CC did want professionals to listen to them and involve them in treatment. Although there is evidence that peer workers working alongside professionals can be highly cost-effective and reduce demands on other services (Repper 2013, p. 13), the implementation can be difficult. Professionals are often attached to their methods and find it hard to accept the expertise of family members (Van Erp et al. 2009, p. 14). When the idea of the CC project was presented to Dr Espinoza, he did not respond positively and said that all Matagalpa needed was an inpatient clinic. Psychiatrists are often focused on clinical management of individuals rather than family-oriented care (Saraceno et al. 2007, p. 7). However, the case of Jonathan, a 23-year-old young man from Matagalpa, shows the potential benefits of family-oriented care. Jonathan had been taken to the psychiatric hospital at least twice a year since the age of 15. He suffered manic-psychotic episodes in which he thought he was God and undressed himself in the street. His mother was convinced that the devil had taken hold of him when he was in this condition. Neighbours would tie Jonathan up and take him to the hospital. After a couple of weeks, sometimes months, Jonathan was stable again. However, he did not continue taking the prescribed medication and soon relapsed. During depressive episodes, Jonathan's mother felt, ironically, relieved because her son would quietly stay in bed all day. However, Jonathan suffered tremendously during these episodes. Regular home visits by volunteer psychiatric nurses from the Netherlands and CC workers led to the mother understanding her son was ill and Jonathan accepting monthly injections. Jonathan is never entirely stable due to temporary unavailability of, or refusal to take, medication; however, hospitalisations have not been necessary ever since.

Local Ownership Versus Foreign Dependency

After one year, the cohesion of CC had strengthened. Family members and patients called themselves one 'big family' and new ideas and activities had been invented. However, it had been a hard time for Rosalba. We had not foreseen that giving a poor woman a paid job would cause so much envy among neighbours and acquaintances. To become someone of status in Matagalpa, as in many poor rural communities in Nicaragua, can put the person in a vulnerable situation and invoke *envidia* (envy) and hostility from other members of the community. It took years before Rosalba received the respect she deserved. This is important to take into account when working through community workers in similar settings. Another challenge appeared as the Dutch government started to reduce its international aid budget as part of restructuring following the economic crisis of 2008. The NGO struggled to raise the necessary funds, and over the next few years, CC operated on a budget of around 5000 US dollars a year. Despite the difficulties, CC aimed to develop itself into a legally recognised NGO with its own office and meeting space. A psychologist was hired to conduct home visits so Rosalba could focus on the management of the organisation. A local committee of family members was set up and procedures to become registered as an official NGO were started. Furthermore, CC became a learning environment where Nicaraguan psychology and nursing students could gain practical work experience and Spanish-speaking Dutch psychiatric nurses, including myself, kept coming to Matagalpa to volunteer, bringing their own expertise and increasing their skills in working across cultures.

> A psychiatric nurse that volunteered for CC searched for a solution to help María understand what her son Matías went through every day. While José was doing better, Matías continued to cause trouble for María. She did not understand why he refused to wear clean clothes and often yelled at him, calling him a pig, which aggravated Matías' restlessness. The nurse made her listen to a recording of 'voices' played through a set of headphones. The voices talked over the top of each other and some of them gave instructions to the listener. This helped María gain an understanding of Matías' experience as she said hearing the voices on the recording made her feel 'crazy'. Consequently the nurse convinced her to visit the psychiatrist with her son. Dr Espinoza advised to mix medication into Matías' drinks to reduce the intensity of his psychotic experiences.[7] In the months that followed there were vast improvements in his behaviour. He started greeting the visiting CC workers and sat down at the table with them when asked to. He also started looking in the mirror again, washing himself and wearing clean clothes. A CC worker accompanied Matías to the market to buy shoes, which required a lot of effort after twenty years of walking barefoot.

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[7] Covert administration of medication is common in low-income countries. In the absence of adequate health services, health professionals and families feel they have no other viable alternative. The ethical aspects of this phenomenon relating to autonomy and consent have been discussed in several studies. Some argue that restoring the patient's capacity serves to promote their autonomy. Others argue that patients can be abused in the process (Srinivasan and Thara 2002: 534–535, Teferra et al. 2013: 6).

> The people in the neighbourhood noticed the changes in Matías' appearance and behaviour and started greeting him again. A complete recovery for Matías is very unlikely after having been psychotic for such a long time but it was touching to see the elderly María getting her son back.

In 2010, the Dutch NGO pulled out because of further government budget cuts and CC alone became responsible for raising all funds. The organisation was urged to look for funding themselves, but this was complex as the family members who ran it lacked knowledge, written communication skills and suitable networks for fundraising. They applied for financial help from the local government but to no avail. The person in charge of mental health policy reported that mental health was not a priority of the Nicaraguan government and therefore there was no budget for such projects.

Nowadays, most funds are raised by private networking and charitable fundraising in the Netherlands. The CC budget largely consists of overhead costs such as wages and rent, which public funds generally are not keen to subsidise. This donor condition is an obstacle to further development and the sustainability of the project. First of all, it is unlikely that CC would continue to exist if work had to be done on a completely voluntary basis. Second, if CC is not able to rent a building, it will not be possible to create a space where people can meet. Eventually, a Dutch family bought a house in Matagalpa to accommodate CC and a laundry service was set up to generate an income to cover CC's overheads. The washing machines were also purchased by charitable donations from the Netherlands.

To strengthen its position and to increase opportunities to influence mental health policy in Nicaragua, CC participates in committees and with federations that are indirectly linked to the goals of CC. Workers from CC join meetings of the Municipality of Matagalpa, the local department of the Ministry of Health and representations from national disability organisations, COMPED[8] and FECONORI.[9] However, compared to physical conditions, mental health care is never top of the agenda. In 2011, CC got involved in an exchange programme of the Association for Training and Research for Mental Health (ACISAM[10]) in El Salvador, and in 2014, this organisation started a four-year project subsidised by the Inter-American Foundation (FIA[11]). The project aims to increase and strengthen a network of users and families in Central America. It wants to help them fulfil their potential to become empowered

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[8] Comisión de Personas con Discapacidad (Commission for People with Disabilities).

[9] Federación de Asociaciónes de Personas con Discapacidad (Federation of People with Disabilities).

[10] Asociación de Capacitación e Investigación para la Salud Mental.

[11] Fundación Interamericana.

partners to improve mental health and be a model for reducing the global gap in mental health and combating the stigma of people with mental disabilities (ACISAM 2014). CC is included as a member, and in 2015 the Central American Network of service users and family members[12] had its first meeting. CC hopes that the forging of links with local and national organisations and membership of the international network will perpetuate its work into the future. However, financial uncertainty remains. The laundry service, the small business that was meant to make CC more independent from external funding, is causing the family members a great deal of stress as the management is complicated and time-consuming in addition to the other activities.

Cuenta Conmigo Today

CC staff currently include a coordinator, a psychologist, a bookkeeper, two laundry assistants and a local committee of volunteers consisting of four family members and one patient. CC works as a team. While each person is individually responsible for certain tasks, they often provide assistance to the others when needed. CC's goals and objectives are still more or less the same as ten years ago and meetings are still held on a weekly basis. Except for the leisure activities, the attendance of meetings is not high. This feature has also been reported by other countries in the Central America Network. Family members in Matagalpa say that they have the most benefit from home visits as they cannot always come to meetings because they have no one to care for their ill relative or other smaller children when they are away from home. Other family members have to work during weekends when meetings are held. In studies on support group participation among lower socio-economic caregivers, other barriers to access are mentioned, such as transportation problems, hesitation over sharing feelings in the group or worry about getting along with other members (Biegel et al. 2004). Given the fact that CC's leisure activities are well attended, identifying more precisely the barriers at work here remains elusive. In surveys carried out to evaluate the activities, family members remain unclear about their motives for not joining group meetings, but they consistently mention that CC has changed their lives in a positive way. Knowing that they are not alone, understanding of the illness and social acceptance are the most frequent benefits reported. There are about 90 families known to CC. On average, 53 are actively involved in the organisation. In 2014, 499 home visits were made. Families find out about CC through posters, public events, radio and local television, but mostly by word

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[12] Red Regional de Salud Mental Centroaméricana: Una red de grupos de usuarios y familiares (Central American Regional Network for Mental Health: A network of user groups and family members).

of mouth. The psychologist is often accompanied by a local psychology student, family member or foreign volunteer. They listen to the stories of the patients and family members and observe them in their home environment. Depending on each individual's circumstances, they offer the family counselling, psycho-education and practical help. They write reports about the home visits. Once in a while, the experiences of patients and family members are assessed through individual surveys using a questionnaire, but structured evaluation of the CC programme does not yet exist. There are no evaluation tools to monitor adherence to therapy, relapses or hospital admissions, and there has never been a baseline measurement. This lack of formal evaluation makes it difficult to prove CC's effectiveness. Until today, CC's success is evident primarily through powerful personal stories[13]:

> The question remained who was going to mix the medication into Matías' coffee when María dies, because he would not take it by himself. María prayed every day, asking God to come and get her sons before her. Her prayers went unanswered and she passed away in 2009. José found her dead in bed early one morning. Several CC board members and family members attended her wake. People were glad that María could finally rest in peace but were also worried about her two sons. After María's death, the neighbours raised money for a few repairs to the small house where José and Matías now lived by themselves. They also bought a bed for Matías. One of María's sisters started to bring daily meals to her nephews and a neighbour became responsible for giving Matías his medication. José and Matías managed with the help of their aunt, neighbour and CC, although José's mental health deteriorated a lot after his mother's death. It became obvious that not he, but Matías had become the stronger of the two brothers. In 2011 José died of stomach problems and Matías remained alone in the small house. CC workers visit regularly and his aunt and neighbour are still looking after his food and medication. The situation is sad, but it would have been worse if Matías had become one of the many psychotic wanderers of Matagalpa. Matías' metamorphosis had made a big impression on the neighbourhood. His neighbours are no longer afraid of him and even cherish him now that he is alone.

Discussion and Conclusion

This chapter describes the emergence of CC, a non-profit organisation for individuals with a psychotic disorder and their families in Matagalpa, Nicaragua, which aims to improve quality of life through education and peer support by

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[13] This qualitative approach to evaluation has also been employed by BasicNeeds who collect first-person narratives as evidence and use these to promote their work.

the means of home visits and group meetings. In Matagalpa, it is seen that valuable money and energy are wasted when solely focusing on clinical management. If families do not get information on the illness symptoms, management of medication and possible side effects, patients continue to relapse or do not stabilise at all. The experiences of CC suggest the huge potential of family-based interventions to improve the quality of life of people with mental illness and their families in low-income settings. The positive outcome of CC's approach has so far only been derived from personal stories and surveys. These narrative accounts are important qualitative data, but the organisation faces the challenge to put into practice a structured evaluation programme to monitor its work and prove its success to policy makers.

The Lancet Global Mental Health Group (2007) calls for scaling up mental health services in low-income countries and developing community programmes to improve mental health practice. However, several barriers have to be overcome. In Nicaragua and many similar low-income settings, financial resources are scarce, mental health is a low priority on the public health agenda and there is a lack of knowledge of mental illness among general health workers. The mental health system in Matagalpa is now limited to psychiatrists prescribing medication and/or referring patients to the only psychiatric hospital in Managua. CC hopes that the Nicaraguan government will invest in community-based care. As Murthy expresses it:

> Developing countries have an unique opportunity to build mental health programmes on the strengths of families. (Murthy 2003, p. 37)

However, he describes three conditions needed to support a family-based approach. Firstly, families require professional support to develop caring skills and access to crisis support and respite care, as well as emotional support. Secondly, families need financial support to replace income lost through caring responsibilities and to help them establish SHGs. Finally, family-based interventions will require significant shifts in attitudes and practices among policy makers and those working in mental health care to develop partnerships with families and make the experiences of the family an essential part of mental health programme and policy development (Murthy 2003).

As for CC, the organisation has been seeking cooperation with the local government but has encountered financial limitations and little official interest so far. The organisation has also been participating in local health committees and federations over the past ten years, but it is hard to get mental health on the agenda. Although CC could play an important advocacy role in the battle for improving mental health practice, the organisation has very limited skills in this area. The Lancet Global Mental Health Group suggests that the World Bank, other development banks, donor agencies in high-income countries and philanthropists invest in strengthening the capacity of consumer organisations and engage them as equal partners (Global Mental Health Group 2007, pp. 94–95). However, negotiating on a macro level is not an easy task and CC workers do not speak English. The recent establishment of the Central American Network to help empower organisations like CC is grounds for cautious optimism. For the time being however, as with many small NGOs, CC continues to depend on private fundraising activities in the Netherlands and the contribution of Dutch volunteers meaning that the future sustainability of the organisation remains uncertain. The experiences of CC suggest the potential value of family interventions in low-income settings. However, more people could share in these benefits if mental health policy makers prioritise the needs of service users and family members, allocate funds for mental health and reorganise health systems around community-based interventions.

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26

The Distress of Makutu: Some Cultural–Clinical Considerations of Māori Witchcraft

Ingo Lambrecht

> I clearly recall the first day I met 'D' in my therapy room at Manawanui, the Māori mental health service in Auckland, New Zealand. As a Māori man in his middle years, D sat opposite me, talking with generous arm gestures, speaking in his rich language of symbols and strange associations. It took all my cognitive skills and some leaps of faith to follow him, to stay with his story. His story was filled with numerous cultural references and anomalous experiences. It was hard to get a grasp on what was going on. He was clearly intelligent, yet difficult to follow in the tangential flow of consciousness he produced, replete with visions, Māori cultural practices, experiences of paranormal phenomena, and tales of terrifying witchcraft, called *makutu* in Māori.

In this chapter, the complex cultural–clinical interface in Global Mental Health will be explored through the lens of psychotherapy with a *tangata whai i te ora* (client) in a New Zealand Māori mental health service. Cultural mental health discourse acknowledges the cultural–political context (Kirmayer et al. 2003). In New Zealand, an academic postmodern sensitivity to cultural factors in the mental health domain is not uncommon (Lambrecht and Taitimu 2012). In the name of postmodern disclosure, the therapist is of German descent, has had the honour of being *whangaid* (adopted or brought into a

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Māori family), and is currently a clinical advisor, integrating various Māori mental health services for He Kamaka Oranga, Māori Health Service at the Auckland District Health Board. Talking therapies have been reviewed for Māori by Māori as being welcomed, effective, and healing, as long as they are culturally sensitively practised (Te Pou o Te Whakaaro Nui 2010). However, how does the cultural–clinical integration in Global Mental Health actually occur on the ground directly in the space between the client and the therapist? The therapy room itself will be contextualized in terms of some political–cultural factors determining Māori mental health services. This is followed by sections on the integrative Māori mental health model, the cultural–clinical entanglements, *makutu* or witchcraft, and finally a brief sketch of D's therapy. The reflections in this chapter have therefore been personalized to capture some of the experiences and thoughts of the therapist, to avoid the notion of the objective, distant, truthful author, sufficiently critiqued in postmodern literature. Through the therapeutic work within a Māori-specific mental health service, the complexity of Global Mental Health for indigenous people all over the world is highlighted.

Coming back to the first session, when I was seeking to understand and formulate, I realized that from a Western psychiatric perspective according to the DSM-5 (APA 2013), the obvious diagnosis of schizophrenia, psychosis, or maybe a manic state with some paranoid ideation and psychotic features would seem to be appropriate. I then was struck by how witchcraft could be considered by Western psychiatric discourse as a form of psychosis, a paranoid schizophrenia. Yet amongst many indigenous people, witchcraft and curses are very real. The question was how to work with this, allowing D to experience his cultural reality. The so-called culture-bound syndromes and the cultural formulation as per DSM-5 (APA 2013, p. 749) are attempts to acknowledge common cultural signs of distress of certain regions or countries. Many countries face the challenge of developing integrative approaches to clinical and traditional health, and mental health specifically. Equally, globalization continues to widen the cultural context in which clinicians have to perform their duties of healing. An increasing number of reviews document racial, ethnic and cultural disparities in mental health care and in continuity of care (Snowden and Yamada 2005). Many explanations focus on cultural factors: trust and treatment receptiveness, stigma, culturally distinctive beliefs about mental illness and mental health, culturally sanctioned ways of expressing mental health-related suffering and coping styles, and client preferences for alternative interventions and treatment-seeking pathways, as well as unresponsive programmes and providers.

A meta-analytic review of culturally adapted mental health interventions finds that many studies advocate for traditional mental health treatments being modified to better match clients' cultural contexts (Griner and Smith 2006). This review finds that across 76 studies evaluating culturally adapted interventions, they have found a moderately strong benefit. Interventions targeted to a specific cultural group were four times more effective than interventions provided to groups consisting of clients from a variety of cultural backgrounds. Interventions conducted in clients' native language (if other than English) were twice as effective as interventions conducted in English. Recommendations suggest mental health interventions be adapted to the cultural context of the client. In the therapy sessions with D, this became the aim, namely using his culture and constructs to establish effective healing.

Māori Mental Health Services

To place the therapeutic space into context, working as a clinical psychologist at Manawanui Oranga Hinengaro Mental Health Services for Māori in Auckland, New Zealand, raises questions about the cultural–clinical interface. The Treaty of Waitangi of 1840 is the central document that addresses the complex and fraught relationship between Māori people and the crown or the state. Māori mental health services were the result of the principles of the Treaty of Waitangi belatedly being applied in 2000 to the New Zealand Ministry of Health's delivery of services. The Treaty of Waitangi in relation to Māori health is understood in terms of the three 'Ps'. Briefly, the Treaty of Waitangi gives Māori the right to 'Participation' in the health system both in terms of access and service, 'Partnership' in terms of power relations and 'Protection' in terms of health and culture (Tapsell and Mellsop 2007).

It has been sufficiently recognized in meta-reviews that Māori in psychiatric services present with different phenomenological profiles at presentation, in the diagnostic patterns, the cost of care, and the therapeutic experiences between Māori and non-Māori New Zealanders (Tapsell and Mellsop 2007). Such differences may be the result of actual differences and/or may reflect inadequacies of diagnosis and treatment by non-Māori clinicians. Māori continue to enter mental health services at a rate that is disproportionately higher than other population groups, twice that of non-Māori and two-and-a-half times that of Pacific peoples with high admission rates (Oakley Browne et al. 2006). Such findings are equally evident amongst indigenous people across the world in regard to higher rates of mental health distress compared to other population groups (King et al. 2009, p. 79). For indigenous people in general, and for Māori specifically, this means that the high number of Māori within such inpatient units requires more effective interventions in order to meet the needs of Māori that ensure better outcomes.

In regard to treatment, similar to other indigenous people across the world, the evidence suggests that *tangata whai i te ora* and their *whanau* (families) wish to have choices in how to integrate conventional clinical mental health service assessments and treatments with traditional and complementary cultural practices and healing methods (Lambrecht and Taitimu 2012). This would be in line with an effective recovery approach that allows staff together with *tangata whai i te ora* to find their unique culturally appropriate healing pathway.

Components of a Māori-dedicated health service would include a Māori workforce with both cultural and clinical competencies, which produce assessments that take into account cultural values, *whanau* (extended family) participation, the use of Māori language and custom (Durie 2001). Māori mental health services are therefore the result of an awareness of a cultural–political position, that is, support for Māori by Māori in the face of white cultural dominance. This approach to treating indigenous people clinically has good validated support in many other countries (Griner and Smith 2006). This position is a form of political activity to protect Māori tradition, language, and practices, which will ultimately benefit everyone in the country.

Importantly, identity is often fluid, seldom fixed, shifting, and reconstituted. Some Māori may identify with being Christian, as with D, who holds a very specific religious position of the Rātana church, a distinctively Māori pan-tribal denomination. Some Māori identify more strongly with aspects of Western cultures and lifestyles, whilst others feel they are excluded from Western cultural practices, as well as having lost their own indigenous cultural heritage. Music and gang culture become spaces for establishing an identity. In regard to my position as a therapist in a Māori mental health service, I lean towards listening to the gaps of what is unknown, the ruptures, the impasses, the underlying dilemmas of the political, cultural, and personal dynamics, as well as the pain. It is then maybe possible to figure out together with the client what may be helpful. I prefer not to know or assume but rather seek to listen carefully to how they personally respond to the cultural and political landscape of their personal background and to the current struggles of mental distress (Lambrecht 2017). I am more curious as a therapist to listen to where a person comes from, how specific identities and relationships are formed, what patterns occur in specific stories. Such stories quickly lead to cultural, political, and economic entanglements. These are always in some way intertwined with the political and the traumatic histories of the land.

It is often not obvious how to apply this cultural–clinical integration on the ground (Lambrecht and Taitimu 2012). It seems that every cultural context requires its own form of integration, but depends also on the specific needs of the indigenous person. It is important to not turn cultural constructs into absolutes. Individuals are shaped and in turn shape their identity. Some challenges may be worth mentioning. One central issue is idealized cultural countertransference, particularly from white therapists, who may romanticize traditional healing and view it in an uncritical manner. This becomes problematic when considering witchcraft (Lambrecht 2014). People have been killed or their lives traumatically altered by such accusations. Witchcraft is an example of a complex indigenous process that has very destructive aspects which challenge any naïve postmodern rhetoric and idealizing view of indigenous constructs.

Another challenge is cultural competency in mental health care (Chowdhury 2012). The Māori mental health services are funded for the top 3% of mental health severity (Oakley et al. 2006), which means they are a secondary mental health service in that referrals arrive from acute inpatient units or from primary health services that cannot manage the severity of the mental health issue. This would include acute psychosis, bipolar and other severe expressions of mood disorders, and personality disorders, to name but a few. To be culturally competent without a significant understanding of mental health is not sufficient. The Ministry of Health document on Māori workforce development (Reanga New Zealand Ltd 2012) has stated that dual competency is required, because in fact it is more complex to work at a culture-specific mental health service. A specialized cultural competency is required to work with complex clinical demands.

Māori Models of Wellness and Distress

Traditional Māori health has a holistic view that engages with social, cultural, and environmental contexts. As a policy paper on talking therapies for Māori states: 'Traditional Māori healing tends to encompass the spiritual and psychological dimensions of health'. (Te Pou o Te Whakaaro Nui 2010, p. 37). In pre-colonial time, the Māori community was protected through *tapu* and *noa. Tapu* was the basis of law and order, what was safe, what is sacred and important. Transgressions of *tapu* lead to mental and physical illnesses, and even death. *Noa*, as the complementary pole of this dynamic, indicates everyday mundane practices and things (Te Pou o Te Whakaaro Nui 2010). For example, I have clinically worked with a person whose onset of hearing persecutory voices, which led to the diagnosis of schizophrenia, was the result of a cultural trauma due to breaking a *tapu* of stepping over the boundary of a cemetery when young. The night after the transgression, the voices emerged (Lambrecht 2015). Witchcraft or *makutu* is another source of illness and death (Te Pou o Te Whakaaro Nui 2010; Hiroa 1910). The use of *karakia* or incantation or prayer calling on the gods or *atua* as well as the interventions such as *mirimiri* (massage) and *rongoā* (herbal medicines) are common traditional interventions (Te Pou o Te Whakaaro Nui 2010).

Manawanui Māori Mental Health Service of the Auckland District Health Board has adopted the Māori mental health model of *te whare tapa wha* (the house of wellbeing) as a holistic model of Māori health or wellbeing. It is made up of the four pillars or aspects of wellbeing, namely *whanau* or the family health, *hinengaro* or mental health, *tinana* or physical health, and *wairua* or spiritual health (Durie 2001). These four pillars hold the protective space of health and wellbeing for Māori and in fact, it could be argued, for most people. The translation into English needs to be taken with care. For example, *whanau* means 'family'; however, the notion of *whanau* in fact embraces a greater net of family compared to the modern Anglo-Saxon nuclear family world. It entails, for example, connections to close family friends and even includes cousins of many degrees removed from the primary family.

All four aspects of Māori mental health are considered to work together, and all aspects are necessary to achieve wellbeing. Hence at Manawanui, clients are called *tangata whai i te ora*, namely a person seeking wellness or balance. Distress is the result of an imbalance of these four aspects, and healing would require ideally the involvement of all four cornerstones. In this manner, Māori mental health is more clinically sophisticated than the common Western psychiatric medical model. This clinical–cultural interface avoids reductionism and also enhances clinical depth and range. In fact, all excellent clinical practice entails cultural and political sensitivities. Equally, in-depth and sensitive cultural work would include clinical aspects. For example, schizophrenia or psychosis within a Māori mental health model is not merely addressed as a brain disease with medication, or is only considered to be an intra-psychic process (*hinengaro*) engaging talking therapies, but rather requires the addition of understanding the *whanau* (extended family), the body (*tinana*), and the spiritual (*wairua*), which leads to an integrated intervention to heal the person.

This model gives me the opportunity to access thinking that Western psychology struggles with, such as body-mind issues, political-systemic processes, as well as to work with 'anomalous' experiences that belong to the *wairua* or spirit aspect of the model (Randal et al. 2008). The *wairua* part can incorporate the findings of parapsychological research and spiritual practices. Māori mental health professionals and clients are often grateful that their worldview and 'anomalous' experiences are not dismissed or considered to be 'crazy' (Bidois 2012). At times, such experiences are reduced to just being 'cultural' (i.e., not real) within academic Western psychological discourse. It is often necessary in my meetings with *tohungas*, the Māori shamans, to apologize because academic Western psychology has many unresolved taboos and resistances in this regard, despite sufficient scientific evidence (Radin 2006). At a Māori mental health service, these spiritual dimensions are openly acknowledged.

Also, there is more scope to work with long-term psychotherapy for complex issues within the clinical–cultural interface, because the *hinengaro* or the mind is respected. This is very different from working within a more medical model of the general mental health system. There needs to be an awareness that the individualistic sense of self is a Western construct, and a Māori client may align with the more socio-centric view of the self (Te Pou o Te Whakaaro Nui 2010). Of course, some Western approaches to psychotherapy, such as family therapy and other models that have adopted a more systemic view, do not subscribe to individualistic orientations. The research into efficacy and effectiveness of talking therapies[1] strongly suggests that the actual models or constructs of therapy and technique contribute only a small amount to the outcome (Wampold 2001). Clinical competency therefore is not merely about clinical models or techniques. This in the Western framework would be referred to as 'therapeutic alliance' (Wampold 2001), which research supports as being central for therapy outcomes. For Māori, this is the *whanau* part of healing, the healing and the holding connectivity between people. From my personal experience as a clinician in the field working with different indigenous groups both in South Africa and in New Zealand, the effectiveness and outcomes of therapy do depend not only on my clinical expertise and knowledge, but much more on my capacity to connect with the person in front of me, to align with the specific personal culture of the individual.

It is beyond the scope of this chapter to outline the various limitations and research of therapies for Māori, but currently, there is a paucity of randomized control trials (RCTs) and outcomes research on the effectiveness of talking therapies for Māori (Te Pou o Te Whakaaro Nui 2010). Nonetheless, despite this, Māori clients in my experience can hold various explanatory models at the same time. This is supported by a growing body of international literature that has found individuals and cultural groups hold multiple explanatory models for mental distress labelled psychotic (Lapsley et al. 2002;

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[1] It is beyond the scope of this chapter to provide a full account of research carried out into psychotherapy specifically with Māori clients. Suffice to say that currently there is a paucity of RCTs and outcomes research on the effectiveness of talking therapies for Māori (Te Pou o Te Whakaaro Nui 2010).

Sanders 2006). For Māori, mental distress, psychosis, and the healing of such experiences require a complex, sophisticated holistic understanding, which suggests comprehensive treatment options (Lambrecht and Taitimu 2012). Working with D was about integrating all these factors as best as possible. The therapy room becomes extended beyond the four walls of the Western individualistic approach (Håkansson 2014) to the wider space of family, the neurodevelopmental body, the land, and spirituality. In one example of such work, Wiremu Nia Nia, a *tohunga*, and psychiatrist Alistair Bush, working collaboratively, have on several occasions been able to establish cultural explanations, such as curses or interfering *tupuna* (ancestors), which have often led to very sudden resolutions of severe psychiatric symptoms that were maintained even after a year's follow-up. They provide a clear example how collaboration between psychiatrists and traditional Māori healing practitioners can enhance the mental health care of Māori (Bush and NiaNia 2012; NiaNia et al. 2013).

At Manawanui, clinical formulations and interventions are placed within the *whare tapa wha* model, as already discussed above. Here at Manawanui, staff and *tangata whai i te ora* are more open to experimentation, that is, to attempt various therapeutic and cultural skills and methods, and consider what specific integration of Western clinical models and indigenous models may be useful and effective. So, for example, mentalization-based treatment (Bateman and Fonagy 2004) has been overtly adapted to this cultural service to work with people who are struggling with deliberate self-harm and complex trauma. Furthermore, a mentalization group has been run successfully for many months. Importantly, this has been carefully discussed in the planning phase with the *kaumatua* (Māori elder) to make the group culturally safe, such as finding a Māori name for it, beginning and ending the group with a *karakia* or prayer, and applying Māori concepts from *te whare tapa wha* (see above) where applicable. The provisional qualitative feedback from clients and staff has been very positive.

In the next section, I will reference some of the Western models of intervention below, so that the reader is aware what skills I have applied, even if in the room, I might give them another name, or use a cultural concept.

Working with Cultural–Clinical Entanglements

Although D gave me permission to tell his story, identifying features have been changed. In our sessions, we explored his *whakapapa* or personal and intergenerational history. It emerged that at a very young age, D lived alone with his warm and loving grandmother until the age of six years. He returned to his family of origin as an emotional stranger, father and mother steeped in alcohol abuse and domestic violence. His father was physically violent towards him and his mother, which drove him to leave the home during his late adolescence. His marital relationship with his partner started to disintegrate in 2008. He stated that it began during a stressful time for his business when he was travelling with his partner and some family members to Rātana, a small but religiously significant place on the North Island, many hours' drive south from Auckland. On this road trip, he began repeatedly to see white horses along the road. For D and his family of origin, white horses were signs or omens of negativity, danger, and vulnerability, which he related to a specific belief in the Rātana church, a Māori movement that was founded by Rātana in 1925 (Mcleod 1963). When he arrived home, already primed to negativity, his disappointment in certain staff at his IT company turned into growing mistrust towards them. He felt cursed by *makutu* (witchcraft), which trapped him in floods of terrifying fear. He believed he needed to protect himself, a common and sensible response within the cultural belief of witchcraft (Best 1982). He tried various remedies, such as keeping away from certain dangerous people, as well as rejecting and throwing out any gifts that he had received from colleagues. He explained to me that a curse from *makutu* can be placed in a gift, which becomes activated at a later date. Finally, D had a sense that his apartment was the only safe place. Even in his apartment, he would move form corner to corner, seeking a place of peace and sleep. Terrified, he finally found a safe and secure place in his garage under his motor vehicle. Soon his business imploded, and with time, as he no longer touched letters, he lost his apartment in the centre of Auckland. For a month, he lived in his motor vehicle, finally coming to the attention of our services because he visited a general practitioner, who referred him to our service. For D, *makutu* had destroyed his world.

The World of *Makutu*

Makutu is the Māori word for witchcraft. A person practising *makutu* is able to inflict illnesses, death, spirit possession to the person bewitched (Best 1982). The effectiveness of *mākutu* is heightened by the secrecy of the bewitchment, a common factor across many indigenous cultures. For Best (1982), the fear of witchcraft leads to a form of order-maintaining adherence to the laws and taboos (*tapu*) of a community, and therefore has a social function. One example highlights how the reality of *makutu* is still very present in some communities. In a suburb of Wellington during October 2007, a woman was drowned and an adolescent hospitalized due to an attempt to remove the curse of *makutu* (The Dominion Post 2007).

Naida Glavish, a senior *tikanga* or Māori culture advisor to Auckland District Health Board, told me about a *makutu* event she had witnessed. She was asked to join a *tohunga* to accompany him on a visit to a very ill man. She recalled how this man's heavy and painful breathing could be heard as they approached the house. The *tohunga* sat with the ill man, and through divination determined that the patient had been bewitched. The man and his *whanau* or family denied this, and could not recall any act or curse of *makutu*. The *tohunga* then got up and went to a framed photograph of their child that was hanging in the corridor. He hit the frame, and a shark tooth fell to the ground. The *whanau* was stunned, and as the *tohunga* withdrew a common cursed object of *makutu* from the house, the breathing of the ill man became quieter. By the time they were outside the house, the breathing could no longer be heard as it was before they entered. For many Māori, *makutu* is a very real negative spiritual power, seeking to hurt others (Glavish 2014, personal communication).

Smith (1921) in his writings claims that those practising *makutu* were usually old men and women. The knowledge of the practice of *makutu* was confined to learned men or *tohungas*. The art of *makutu* was practised in secret. The *tohunga-titiro-mata* (healers) had always power to kill the *tohunga-makutu* (sorcerers), and the latter had great fear of the former. Each person used *karakias* (incantations, prayers) over him or herself to stay secure from witchcraft. All other illnesses are minor compared to the afflictions of *makutu.* In ancient times, a house of training was called a *whare kura* or *whare wānanga* in which *makutu* was taught to some. It was considered a lower form of spiritual power. The mode by which the *makutu* is used against anyone takes the form of an incantation or *karakia* that will be quietly but powerfully uttered from the tip of the tongue. In fact, the *tohunga-makutu*, though feared, was also despised and condemned for such evil practices (Shortland 1882). Māori in the past as a warlike people looked upon fame in the battlefield as the highest honour, and the cowardly method of killing one's enemy secretly by means of incantations was condemned as murder (Hiroa 1910).

A Brief Sketch of Therapy with Witchcraft and Paranoia

In therapy with D, after establishing that there were no concerns of safety and risk issues, the first aim was to reduce his intense painful emotional dysregulation. So with D, we explored the *whakapapa* or genealogy of his trauma.

We explored the early years or his *whakapapa* to understand his intergenerational traumatic and abusive past, and how this may be related some of his unusual paranoid or psychotic experiences. The personal and the political intertwined at this point in that D was able to appreciate that the severe alcohol abuse of his parents was the result of not coping with the traumatic land loss imposed by the government on his grandparents. This created an important shift for D, as he felt that he was not just an unwell individual, but that his distress was related to the politics of the land. He stated that he felt he had more *mana* (personal power) because of this insight. His internal battle had a deep connection to political injustice of colonization; it was not based on some inherent weakness. This work was based on an integration of the *whare tapa wha* model, and on psychodynamic and developmental formulations of his *whanau* (extended family) and intergenerational trauma, involving the *tinana* (body) effects defined by a trauma neurodevelopmental model (Read et al. 2001). The intergenerational political-personal trauma affected the complex personal and cultural web of family systems, neurodevelopmental factors, and his inner world.

In therapy and in his life, D presented with signs of hypervigilance, avoidance, had some startle responses, and struggled with intense emotional dysregulation (Schore 2003). When unpacking his *whanau* or familial past emotional *whakapapa* (genealogy), it was helpful to address his attachment and mentalization (*hinengaro*) issues. His positive relation with his grandmother, a significant attachment figure in Māori *whanau* (Glavish 2014), was central as a protective factor in the face of very early pre-verbal neglect. In regard to his relationships, we explored and mentalized other options carefully, such as that at certain times people around D were possibly responding with fear to his increased agitation, hence withdrawing from him out of fear, and not only because of *makutu*.

Also, large sections of therapy explored his paranormal experiences, which are beyond the scope of this chapter and are explored elsewhere (Lambrecht 2017). However, it was central for him to be culturally safe and feel understood by his therapist. Because of a sense of respect and engagement with his culture in the sessions, working with witchcraft or *makutu* became possible by gently allowing for a discerning approach that does not deny experiences of fear, but carefully checks whether this is related to past patterns within him, or whether he experienced some synchronistic or anomalous experiences. Mentalizing others more carefully (Bateman and Fonagy 2004), and checking carefully whether he was being cursed or not, was helpful. At certain points, he could acknowledge his hypermentalization when it came to certain specific incidences of *makutu*. No attempt was made to deny or agree with *makutu*, but rather to become discerning, reminding him that even traditional Māori healers or *tohungas* would not always assume *makutu*. *Tohungas* were equally discerning, and sought proof. With time, he began to settle, his thinking and feeling became clearer and regulated. He began after many months to build up his own business again. He first became fearful of remission, so gently exploring risk factors and supporting him with stabilizing dialectical behaviour therapy skills (Linehan 1993) were central. Self-soothing skills and being reflective and effective in mentalizing also led to positive outcomes in regard to relapse and remission. He found this integrative style of therapy helpful, using cultural concepts that fit or are close to the therapeutic concept, thereby creating congruence. Another important factor was our therapeutic relationship, for trust is more effective than rhetoric. He appreciated that personal trauma is political trauma. Through either therapy, rituals, and shamanic interventions, such attacks of either real or perceived witchcraft can be healed through achieving a sense of spiritual balance, protection, and the calming effects of down-regulation, that positively attunes the nervous system together with the whole inner psychological space, as well as harmonize cultural and social relations.

Conclusion

As stated above, today, indigenous people hold various indigenous and Western explanatory models in mind, and D was curious in his therapy about our integration of his cultural concepts with other models of understanding his terrifying distress. The Māori model of wellbeing, the *whare tapa wha*, was never lost in the various formulations and interventions described above. As this specific therapeutic field of cultural–clinical integration was explored, D remained open to experimentation. Such formulations seemed to receive interesting spins. These overlays synthesized various ideas into a functional whole. Within a holding relationship, be it by a *tohunga* or a therapist, the effects of inner and outer evils and distress can be safely averted and healed. I consider it important to remain open to those with whom we are working. Every person is different, and forcing people into fixed cultural or clinical models places people at risk. Therefore, cultural and clinical competency requires, besides rigorous and in-depth understanding, flexibility and openness as both healing and cultural practices are always shifting and changing. Therapy within cultural–clinical entanglements is more like a dance rather than a manual, so popular in certain Western models; it is more like a jazz improvisation, rather than a formula.

The aim of exploring the specific cultural–clinical work at a Māori mental health service may raise some issues that are of some relevance to Global

Mental Health for other indigenous people. For example, in thinking about mental health services for indigenous people, it is worth establishing a specific model of indigenous understanding or cultural knowledge of what constitutes distress and wellness for a specific people. It needs to encompass cultural, but also political, social, spiritual, and clinical issues, be it poverty, substance abuse, local political structures, and so on. It is beyond the scope of this chapter to examine the full intricacies of mental health services development for indigenous people across different settings. However, it is worth mentioning that elders or experts within a culture have a responsibility to explore the richness and sophistication of their culture to bring forth both ancient and new knowledges in regard to the health of their people. Political leaders and policy makers in mental health, who are setting up a mental health service in countries that serve indigenous communities, then have the responsibility to first listen to cultural knowledges, and, together with the indigenous people, to explore the cultural–clinical interface. As already stated, Global Mental Health discourse has established that indigenous people seek their own specific integration of cultural and clinical knowledges and interventions. There are no simple manualized answers; rather, it is worth maintaining flexibility at the cultural–clinical interface, as times and communities change.

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27

Engaging Indigenous People in Mental Health Services in Australia

Timothy A. Carey and Dennis R. McDermott

The engagement of Indigenous Australians in mental health services is an important, current issue which, as yet, has not been addressed effectively in a widespread or sustainable way. While effective initiatives can be identified from time to time, these tend to be isolated efforts situated against mainstream policies and practices, which, for the most part, endorse a Western biomedical approach to mental health that is not always relevant, appropriate, or helpful for Indigenous Australians. In this chapter, we use the term 'Indigenous Australians' to refer to both Aboriginal and/or Torres Strait Islander Australians.

We begin this chapter by examining the historical context of current Indigenous Australian mental health status, concentrating on events after European settlement. Appreciation of the impact of the colonising process over the last 200 years is central to comprehending the complex, contemporary mental health consequences on those so colonised, as well as developing

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an appropriately conceptualised, nuanced praxis with which to respond efficaciously. After providing some historical information, we outline details about the present status of Indigenous Australians from a health perspective, including mental health.

The health status of Indigenous Australians lags unacceptably behind that of other Australians on almost any indicator chosen. Part of the problem in the area of mental health may be that mental health is construed differently, both conceptually and practically, for Indigenous Australians compared to non-Indigenous Australians, yet many of our mental health services have still not recognised this or adapted to it. Where the perceived utility, cultural consonance, or personal acceptability of the mode and manner of care on offer is deemed to be lacking, the uptake of that service will be constrained. By detailing both the current health status of Indigenous Australians and the social determinants of health contributing to that status, we intend to convey that improving service engagement by Indigenous Australians involves not just the provision of services but also ensuring that access to these services is, in fact, realised.

In a general sense, the current provision of mental health services for Indigenous Australians is both inappropriate and inadequate (Dudgeon et al. 2014; Westerman 2010). While there is a lack of reliable studies in the area of Australian Indigenous mental health and social and emotional well-being, the available evidence indicates that there is a pronounced separation between the mental health status of Indigenous and non-Indigenous Australians, and this disparity is increasing in some areas (Dudgeon et al. 2014). There is an urgent need, therefore, to find effective and sustainable solutions.

The final section of the chapter discusses some of the implications for mental health services in respecting and reflecting Indigenous Australians' understanding of mental health, as well as some guidelines for making services more meaningful from Indigenous perspectives. Ironically, making mental health services more engaging and effective for Indigenous Australians may also make these services more effective for many non-Indigenous Australians. Frequently, non-Indigenous Australians still do not appreciate how much they can learn from Indigenous Australians, and this chapter is a contribution to correcting this situation so that all Australians can enjoy robust states of mind and live satisfying, meaningful lives. The argument we are presenting here, of the non-immutability of Western concepts of mental health, can be situated within a broader debate in which the framework of Global Mental Health itself is questioned (Summerfield 2013).

The Historical Context of Indigenous Australians' Mental Health and Well-Being

It is estimated that Indigenous people had lived in what was to become known as Australia for between 40,000 and 60,000 years prior to European colonisation. During this time, there were more than 250 different language groups, reflecting a diversity of cultures across the continent. The peoples of this land suffered from few diseases compared with Europeans. While Europeans had to contend with health problems such as smallpox, measles, influenza, tuberculosis, scarlet fever, venereal syphilis, and gonorrhoea, these were unknown to Indigenous Australians (Macrae et al. 2013). Also, Indigenous Australians had a sophisticated system of land management to the extent that wildlife and plant foods were generally plentiful throughout the year and the landscape had a park—or estate—like quality to it (Gammage 2011).[1]

After European contact, introduced diseases were a major cause of death for Indigenous people, and conflicts stemming from the European occupation of Indigenous homelands made substantial contributions to Indigenous mortality (Macrae et al. 2013; Reynolds 2013). Before colonisation, Indigenous people were free to determine for themselves the ways in which their lives would unfold. Once Europeans began to spread across the country, however, Indigenous people's capacity for healthy living was compromised through the disruption of relationships, the dispossession of land, the elimination of traditional foods, and a general devaluing of cultures (Macrae et al. 2013). The general loss of autonomy initiated a cycle of dispossession, demoralisation, and poor health that has continued to the present day (Macrae et al. 2013). The phenomenon has been dubbed 'historic' (Duran and Duran 2005) or 'collective' trauma (Atkinson 1997; Krieg 2009), although Kirmayer and colleagues have cautioned against a presumption of any automaticity of simple intergenerational transmission, arguing that contemporary 'structural violence' must be factored in—and may possibly be more corrosive of Indigenous well-being (Kirmayer et al. 2014, p. 313). The maintenance, or re-vitalisation, of culture has been connected to resilience in the face of colonisation's destructive effect on well-being (Kirmayer et al. 2003). Resilience,

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[1] The term 'estate' should not imply European notions of land sequestration for the benefit of the fortunate few. It, rather, conveys the alternative reading of 'well-managed land', which was worked to provide the resources needed by the whole group through such means as: 'fire-stick farming'; sustainable, strictly-seasonal food-gathering; and intricate riverbed fish traps. Incoming colonial authorities did not recognise such unfamiliar 'management'—an important precursor to dispossession and the legal fiction of Terra Nullius: 'land belonging to no one'.

however, may be undermined by the widespread erosion of the opportunity to conduct everyday Indigenous lives framed within Indigenous cultures. Most Indigenous Australian languages, for example, have already vanished, and it has been estimated that these languages are dying at the rate of one or more per year (Nettle and Romaine 2000).

The effects of colonisation on well-being are profound. Awareness of Indigenous Australians' lack of resistance to disease at colonisation is widely known; however, the widespread and long-lasting occurrence of violent frontier conflict is much less recognised. The historian Henry Reynolds now terms it the 'Forgotten War' (Reynolds 2013). Apart from such direct impacts of colonial expansion (and the resultant depopulation and trans-generational trauma), the imposition of colonial authority—delivered through both formal policies and widespread informal practices, jointly dubbed 'Clayton's apartheid'[2] (McDermott 2004)—has contributed powerfully, though less obviously, to contemporary Indigenous mental distress (Commonwealth of Australia 1997; McDermott et al. 2008). Particularly pertinent was the emergence of a suite of mechanisms fostering widespread, sustained practices of forcible child removal—most commonly referred to, in both Indigenous and non-Indigenous Australian parlance, as the 'stolen generations'. By the late nineteenth century, the population of Australian people who were solely of Indigenous descent was declining, yet that of Indigenous Australians with also European, Afghan, Chinese, or other ancestry was increasing (Commonwealth of Australia 1997). Government officials reasoned that if Indigenous children were forcibly removed from their families and sent away from their communities to live in group homes, or work for non-Indigenous people, then, over time, the mixed-descent population would 'merge' with the non-Indigenous population (Commonwealth of Australia 1997). 'Merging' eventually became 'assimilation', with the introduction of legislation under the pretext of child welfare.

It is estimated that, from 1910 to 1970, between one in three and one in ten Indigenous children were forcibly removed from their families and communities (Commonwealth of Australia 1997). The effects of these removal practices cannot be overstated. Removal affected the removed children, as well as parents, siblings, family groups, and communities. The *National Inquiry into the Separation of Aboriginal and Torres Strait Islander children from*

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[2] 'Clayton's' ('virtual' or 'de facto') apartheid takes its cue from ironic Australian vernacular usage of the non-alcoholic, scotch lookalike, Clayton's (Kola) Tonic. The long-running advertising catchphrase was: 'The drink you're having when you're not having a drink'.

their families (often referred to as the *Bringing Them Home Report*) was told repeatedly about the damage to children who were removed, and the effects on subsequent generations whose parents and grandparents were forcibly removed, who had their Indigeneity demeaned, and who were often otherwise traumatised and abused (Commonwealth of Australia 1997).

The importance of attending to the potential role that trauma plays in the emergence of complex mental health problems has been highlighted. For example, Morrison et al. (2005) highlighted the association between trauma and psychosis. Internationally, moves for a fresh focus on the role of trauma in mental health and well-being have paralleled by those arising from research with Indigenous Australians (Atkinson 2002). This has in turn led to calls for trauma-informed services, offering trauma-specific care, at least for Indigenous Australian children (Atkinson 2013). Given this emphasis, the population-level 'trauma history' undertaken in this chapter offers a way to better comprehend a number of historically generated social determinants of Indigenous Australian mental health, as well as how they might interact with a range of contemporary determinants. We posit that, in the Indigenous Australian context, the deliberative manner, widespread scale, and trans-generational impact of forcible child removal requires consideration, and response, as a social determinant in its own right. In recognition of the complex interaction of the past and the present, one of this chapter's authors (DRMcD) has proposed a schema (see Fig. 27.1, below) to facilitate comprehension of the dynamic constitution of Indigenous mental distress, which can be seen as:

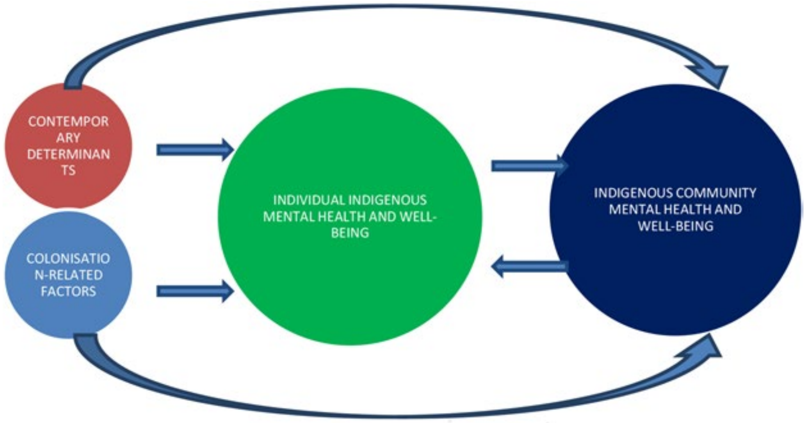

Fig. 27.1 Interacting dimensions of Indigenous Australian mental health and well-being

> [a] core of colonisation-related factors, surrounded by a range of contemporary determinants, all mediated by a variable exposure to trans-generational trauma. Racism, thus [for example], may oxygenate 'historic' or 'collective' trauma. (McDermott 2008, p. 22)

Figure 27.1 depicts individual Indigenous mental health as 'nested' within wider Indigenous community well-being. Contemporary social determinants have impact at both an individual and community level, as do the contemporary consequences of colonisation-related factors at the 'core' of the schema. After Krieg's (2009) and Atkinson's (1997) extension of the notion of 'collective' trauma to the Indigenous Australian context, the model also allows that the sequelae of such trauma, while operating at the community level, also flow back to the individual person. As Krieg notes, drawing on an earlier application of the notion to communities' post-natural disaster:

> Collective trauma allows us to acknowledge traumatized communities as something more than assemblies of traumatized persons and it can do so without unduly pathologizing feelings, behaviours or individuals. (Krieg 2009 p. S30)

The Current Context

According to the 2011 census, Indigenous Australians comprise approximately 3% of the total Australian population (Australian Indigenous HealthInfoNet 2013). Indigenous women have more babies (2.7 on average compared with 1.9 for non-Indigenous Australian women) and have them at a younger age than non-Indigenous Australian women (Australian Indigenous HealthInfoNet 2013). The infant mortality rate is also higher for Indigenous babies compared with non-Indigenous babies (Australian Bureau of Statistics 2013). The life expectancy for Indigenous Australians is approximately ten years, or more, less than non-Indigenous Australians (Australian Indigenous HealthInfoNet 2013). Between 2006 and 2010, the leading causes of death for Indigenous Australians were cardiovascular disease (including heart attacks and strokes), cancer, and injury (including transport accidents and self-harm) (Australian Indigenous HealthInfoNet 2013). Diabetes is also a major health problem for Indigenous Australians (Australian Indigenous HealthInfoNet 2013). The contribution to psychological distress of corrosive individual and community levels of grief and loss—arising from early mortality and a heavy burden of morbidity and disability—should not be overlooked (De Maio et al. 2005).

According to the 2008 National Aboriginal and Torres Strait Islander Social Survey, Indigenous compared to non-Indigenous Australians, above the age of 18, are 2.6 times more likely to experience high or very high levels of psychological distress (Macrae et al. 2013). Also, a significantly greater proportion of Indigenous compared to non-Indigenous Australians reported feeling sad and without hope. Perhaps paradoxically, however, 90% of Indigenous Australians in this survey reported feeling happy either some, most, or all of the time (Macrae et al. 2013). These findings of high levels of psychological distress coupled with a large proportion of people reporting happiness at least some of the time might suggest that concepts such as mental health, psychological distress, and well-being need to be understood, or articulated, differently with Indigenous Australians than they are with non-Indigenous Australians. The findings also imply that the assessment instruments used to collect data on areas such as psychological distress may need to be tailored to remain cognisant of culturally or contextually specific explanations.

Mental Health and Indigenous Australians

The way one defines a particular concept has important implications for the way in which programmes and services might be developed and delivered. This is particularly the case in the area of mental health. If one understands psychological problems according to the nosology described in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5; American Psychiatric Association 2013), for example, then specialised programmes and services might be developed to treat discrete disorders such as schizophrenia, borderline personality disorder, or generalised anxiety disorder. If, however, a nosology such as the DSM-5 is found to lack validity for classifying distress experienced by particular populations, then the programmes and services traditionally linked to this diagnostic system may prove inappropriate also.

Krieg has noted the 'recurring cycles of unresolved grief and traumatization that have been repeatedly identified by Indigenous peoples as major factors compromising mental health and well-being' and yet, also, described a 'profound mismatch with existing mental health constructions of trauma' (Krieg 2009 p. S30). One of this chapter's authors (DRMcD) has described the developing interest, from an Indigenous perspective, in the assessment of *non-specific mental distress*, noting that:

> Not only are the clarity and aetiology of many specific diagnoses [deemed] questionable but, also, the distress displayed is supra-individual and is tied, inescapably, to colonisation and its sequelae. (McDermott 2008, p. 23)

In Krieg's terms, there may be no one distinct, 'legitimate' traumatic event to be ascertained:

> Colonization was not a moment. It is an ongoing experience with multiple persistent contemporary traumatizing events continuing to impact daily on Aboriginal families and communities. These include the ongoing colonizing practices of social marginalization, incarceration and racism in all its forms, and the retraumatization associated with family violence, sexual abuse, self-harming and substance misuse. (Krieg 2009 p. S30)

Within Indigenous and pan-Indigenous Australian perspectives, then, 'mental health' is a necessary but insufficient premise for organising effective responses. The preferred term for Indigenous Australians is 'social, spiritual, and emotional well-being' (Swan and Raphael 1995). This term recognises the legitimacy of factoring in the social determinants of Indigenous psychological distress and the necessity of incorporating colonisation-related trauma, grief, and loss. The term used by Swan and Raphael (1995), among others, comes from a definition of Indigenous health outlined in the National Aboriginal Health Strategy (NAHS 1989).[3] The definition in the NAHS claims that Indigenous health is:

> Not just the physical well-being of the individual but the social, emotional, and cultural well-being of the whole community. This is a whole-of-life view and includes the cyclical concept of life-death-life. (National Health Strategy Working Party 1989 p. x)

It is important to notice in this definition that a distinction is *not* drawn between physical and mental health. Rather, the functioning of the individual in that individual's cultural, social, and physical context is considered important. Alex Brown and his colleagues have conducted important work in this area demonstrating, among other things, the inextricable link between cardiovascular disease and depression, and that the determinants and expression of depression for Aboriginal[4] men in Central Australia are different from the way

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[3] The National Aboriginal Community Controlled Health Organisation (ACCHO) describes NAHS as being 'built on extensive community consultation to produce a landmark document that set the agenda for Aboriginal health and Torres Strait Islander health'. The Working Party comprised two Commonwealth Government representatives (including an Aboriginal Chairperson), eight State Government representatives, and nine Aboriginal community representatives.

[4] Indigenous Australians employ a large range of self-descriptive terms, which may be applied differentially depending on context and/or preference. The term 'Aboriginal' is used in this context because this is the term that is used in the original study.

depression is characterised for mainstream populations (Blashki and Brown 2005; Brown et al. 2012).

The broadly encompassing notion of ideal day-to-day functioning was conveyed more clearly in the page before the definition offered in the NAHS document. Specifically, it is stated:

> Health to Aboriginal peoples is a matter of determining all aspects of their life, including control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity.
>
> Prior to colonisation Aboriginal peoples had control over all aspects of their life. They were able to exercise self-determination in its purest form. They were able to determine their 'very-being', the nature of which ensured their psychological fulfilment and incorporated the cultural, social and spiritual sense.
>
> In Aboriginal society there was no word, term or expression for 'health' as it is understood as in Western society. It would be difficult from the Aboriginal perception to conceptualise 'health' as one aspect of life. The word as it is used in Western society almost defies translation but the nearest translation in an Aboriginal context would probably be a term such as 'life is health is life'.
>
> In contemporary terms Aboriginal people are more concerned about the 'quality of life'. Traditional Aboriginal social systems include a three-dimensional model that provides a blue-print for living. Such a social system is based on inter-relationships between people and land, people and creator beings, and between people, which ideally stipulates inter-dependence within and between each set of relationships. (National Health Strategy Working Party 1989 p. ix)

The implications of these four paragraphs are profound for the way in which Indigenous mental health might be understood and the way in which services and programmes should be designed (Carey 2013b). It is instructive, for example, that Indigenous Australians did not have a word for 'health' in their languages as it is understood in Western discourse. Also, the importance of control and self-determination are strong themes. Programmes and services, therefore, as well as policies, should pay careful attention to control and the impact their interventions have on the ability of Indigenous Australians to control the things that are important to them (Carey 2013b).

If more effective services are to be designed, it is important to embrace the difference between Western concepts of mental health and Indigenous Australians' understandings of social, spiritual, and emotional well-being. Throughout the literature, there is evidence of what appear to be attempts to understand the psychological problems of Indigenous Australians through a Western lens. For example, Parker (2010) states that:

> *Notwithstanding the above cultural factors*, psychotic disorders have been reported in a number of cases of the traditional Aboriginal and Torres Strait Islander context. (p. 69, emphasis in italics added)

A propensity to view culture as something that masks or hides the 'real' mental health disorder is a common theme in the literature. Drew et al. (2010) write that:

> Another key feature of mental health concerns is that for Aboriginal people the manifestations of mental disorders can take forms that are unique to their culture and experience. (p. 193)

Here, again, it seems that the Western mental health disorder has assumed a more important status than culture and experience. Sheldon (2010) states the case even more clearly when he claims that:

> Even with the obscuring effects of cultural beliefs (i.e. thought-sharing, hallucinations and possession by spirits), *schizophrenia* and *schizophreniform psychosis* could be identified if there was good corroborative history of grossly disturbed behaviour and the community viewing the person as rama (or local words for 'madness'). (p. 220)

In a discussion about mental health in Indigenous settings, Hunter (2014) makes the point that:

> While there are differences in the prevalence of certain conditions cross-culturally, it is prudent to be guided by the assumption that if it can happen in the mainstream it can also happen in an Aboriginal setting. (p. 26)

This may or may not be true depending on what one's understanding of 'it' is. There is no doubt that humans across the globe have the capacity to experience a variety of emotional states such as elation, despair, misery, contentment, and joy. It is quite another matter, however, to contend that Western constructs of 'depression' and 'anxiety', for example, apply cross-culturally. There is evidence, for example, that, while depressive symptomatology exists in Australian Indigenous men, it is not characterised by hopelessness as Western depression might be, but, rather, it is characterised by a weakness or injury of the spirit resulting from factors such as a loss of connection to social and cultural life and marginalisation (Brown et al. 2012). As Aboriginal educator, Dr Bob Morgan, rhetorically asked an Indigenous Men's Health Conference audience: 'How do you get cured of spiritual sickness?' (Morgan 1997).

Summerfield (2013) questions how transportable Western mental disorders are to other cultures given that they are grounded in Western culture. He argues:

> It is a lamentable error of epistemology, a category error, to assume that because phenomena can be detected in one setting or another, they mean the same thing everywhere. (p. f3509)

In another jurisdiction—with both colonial parallels and differences, but strongly influenced by Maori-originated notions of cultural safety—the New Zealand Psychologists Board specifically requires of registered psychologists that:

> the psychologist delivering the psychological service will understand and recognise the cultural origins, assumptions and limitations of certain forms of psychological practice within some cultural contexts. (New Zealand Psychologists Board 2014, p. 16)

Reser (1991) suggests that:

> [a]n adequate understanding of psychopathology in other cultures does not exist, and it will be realised only when there is a more widespread and genuine understanding that there exist basic cultural differences with respect to how the world, the self, and distress are experienced and responded to. (p. 221)

Grieves (2009) endorses this view with her extensive review and critique of Aboriginal spirituality. Grieves emphasises that Indigenous Australians' notions of spirituality, as with concepts of health, have no easy translation into English but refer to:

> the basis of our existence and way of life that informs our relationships to the natural world, human society and the universe. (p. 3)

In this chapter, we are not questioning the *possibility* of demarcating Western-style mental health disorders in the behaviour and conduct of Indigenous Australians. We are questioning why anyone would want to. The Indigenous mental health literature provides no clear utility for treatment and outcomes through reliance on Western praxis. The search for clear diagnoses may be quixotic: a real honouring of the complexity of Indigenous mental distress involves re-assessing accepted modes of assessment that are often systemically insisted upon. Haswell-Elkins and her colleagues have noted our 'limited capacity to assess [Indigenous mental disorder] at individual, community and societal levels' (Haswell-Elkins et al. 2007, p. S29). Similarly, Eley and colleagues report on patient and family perceptions of the inappropriate diagnostic and interventional consequences flowing from:

> Major gap[s] in communication between mental health staff and Indigenous patients. (Eley et al. 2006, p. 36)

Given that the current relationship between non-Indigenous and Indigenous Australians reflects a profoundly disturbing coloniser/colonised history, the health system can itself be a hostile, and at times, racist environment. Australian Indigenous psychologist Tracey Westerman (2004), drawing on the work of Hunter (1988), describes a further caveat to an uncritical reliance on supposedly valid Western assessment modes: 'Indigenous people assessed in "foreign or sterile environments" may present as significantly more distressed than usual' (Westerman 2004, pp. 2–3). Westerman also noted:

> many examples of misdiagnosis, under-diagnosis and over-diagnosis occurring with Indigenous people as a direct result of assessment outside of their country/community or preferred cultural context. (Westerman 2004, p. 2)

This Indigenous Australian-specific literature reinforces the wider contention that the Diagnostic and Statistical Manual (DSM) system of classification as advocated by the American Psychiatric Association has no particular scientific legitimacy, and there are increasing calls to abandon it (e.g., Timimi 2011) or to replace it with other systems (e.g., Insel 2013). There is a growing recognition that, even for Western society, the DSM is simply the wrong way to understand psychological functioning (Carey 2013c). Seizing the opportunity, therefore, to learn from Indigenous Australians would almost certainly be beneficial for this group of Australians, but, in all probability, it would also be beneficial for non-Indigenous Australians.

Implications for Engagement in Mental Health Services

In Durie's (1997) term, Western paradigms of 'mental health' suffer from 'conceptual isolation': it is the limited conceptual base that constrains the development of services, assessments, interventions, and even practitioner training that are relevant and effective for Indigenous Australians (Durie 1997; Thorpe and McKendrick 1998). Existing psychiatric diagnoses often provide neither an acceptable fit with Indigenous explanatory models of illness (Gabb and McDermott 2008), nor facilitate an appropriate service response (Swan and Raphael 1995; Brown et al. 2012; McKendrick and Thorpe 1994). Westerman has described usual, 'mainstream' practice as offering a:

> [l]imited base of specialised therapeutic interventions steeped in conceptual, evidence-based treatment models. (Westerman 2004, p. 4)

What is required, rather, is an expanded praxis—an 'Indigenised' praxis—based on a conceptual framework that is holistic in both structure and implementation.

Currently, engagement in services is compromised by bio-medically premised configurations that inadequately address Indigenous preferred responses. Complex presentations are common, with court and justice issues, family violence issues, problematic alcohol and other substance use, child protection questions, and housing insecurity inseparably relevant to any mental distress intervention (Krieg 2006; Cripps 2010; Tilbury 2009).

Two logical consequences of the argument that we have made, thus far, in this chapter are that control and self-determination will be necessary elements of any effective and sustainable solution, as will be the acknowledgement and accommodation of Indigenous perspectives. Endorsing the importance of control and self-regulation will necessarily entail incorporating stakeholder involvement in the design and implementation of mental health services. This point will be returned to later in the chapter.

Control is also fundamental to the social determinants of health with Marmot (2006), reminding us that:

> What is important is not so much what you have but what you can do with what you have. (p. 565)

While the important link between social determinants and physical health is well established, it is also being increasingly recognised that social determinants are just as important to mental health (CSDH 2008).

In order to address the engagement of Indigenous Australians with appropriate services, it is essential, also, to be clear about what is meant by 'engagement'. One approach is to consider mental health services as resources that people can use to make their lives more as they would like them to be, not as programmes or plans that are applied to individuals to shape or mould them in particular ways. There is a connection here between enhancement of the 'control factor', client-centred service configuration, and facilitating resilience—all in the name of better mental distress outcomes. The work of Michael Ungar and colleagues, across a number of international settings, re-positions resilience as something greater than individual 'defiance-of-the-odds'. In the context of exposure to significant adversity, resilience can instead be seen as:

> both the capacity of individuals to navigate their way to the psychological, social, cultural, and physical resources that sustain their well-being, and their capacity individually and collectively to negotiate for these resources to be provided in culturally meaningful ways. (Ungar 2014, n.p.)

Service engagement, from such a perspective, then, begins from a premise of Indigenous Australians being active agents rather than passive recipients of services. It also implies that when services are not being engaged by Indigenous Australians, we should address the service being offered, rather than the person who is currently not taking up the offer. It is important, therefore, to consider engagement from a perspective informed by the needs, desires, and lived reality of the person accessing the service, rather than from the perspectives of the service providers.

Grieves (2009) argues that something much more radical is required than making premises 'Aboriginal-friendly' and providing cultural awareness training for practitioners. A service, for example, that prominently displayed Indigenous artwork and ensured all employees had some cultural awareness training yet still diagnosed and treated mental health problems according to Western standards would be missing the point. Berry and Crowe (2009) endorse this view by suggesting that difficulties with engaging Indigenous clients relate to both limited access to services and a lack of cultural respectfulness of the services. The lack of culturally derived empirical models of practice that are applicable, particularly to Indigenous youth, is cited as another reason for poor engagement with services (Westerman 2010).

In one study, participants perceived that Western-style therapy was culturally inappropriate or irrelevant (Vicary and Bishop 2005). In this study, fear of the Western mental health system was reported by Indigenous Australians because of the stigma associated with being labelled mentally ill, as well as the possible imposition of certain treatments, such as involuntary hospitalisations and medication. Vicary and Bishop (2005) point to the implications for Indigenous engagement with mental health services in noting that participants in their study:

> actively withheld mentally ill family members from Western services because they were concerned about the possible outcomes. (p. 12)

It is not that fears of stigma and compulsory treatment only bedevil Indigenous Australians: what is noteworthy with respect to Indigenous engagement, rather, is that such fears are compounded by not only historical factors—sometimes generic to the project of colonisation itself, and sometimes specific to the Australian context—but also the impact of a range of contemporary determinants of Indigenous mental health and well-being. Relevant historical factors would include: the past existence of segregated hospital wards; a body of anecdotal (though substantial) evidence of past, forced sterilisations; and the body blow to trust of widespread forcible child removal over many decades—where doctors, hospitals and other health system actors were viewed as active agents in the processes contributing to the 'stolen generations'. Contemporary barriers to resolving the twin impediments of reluctance to engage and early dis-engagement—including even self-discharge, or 'taking own leave', in life-threatening situations, before the completion of the interventions or treatment—revolve around perceptions of a lack of cultural safety in the health service on offer (Einsiedel et al. 2013). Given recent research suggesting that racism in health settings may have a more negative impact than racism in other settings (research that echoes long-standing Indigenous Australian narratives of how health services can make them feel 'sick'), adding the likelihood of encountering racism to concerns about inappropriate modes of health-care delivery may lead to greater risk of dis-engagement (Kelaher et al. 2014).

Any discussion about the importance of perspective, however, would be incomplete without including reference to the unequal power relationship between client and professional—and the way in which this imbalance can inform, or hamper, service delivery. To provide services that Indigenous Australians would want to engage with, it is crucial for service providers to be aware of their own assumptions, attitudes, beliefs, and values. This requires not only fostering health professionals' reflection on their own culture in relation to therapeutic interactions but, also, the re-positioning of such reflective practice as the default setting for effective cross-cultural work, that is, as *core* clinical, health promotional, and organisational business. One exemplar approach which encapsulates the need for the mitigation of power differentials—for the development and embedding of self-reflective practice, and for treating clients 'regard-ful', rather than regardless, of difference—is the earlier mentioned approach of cultural safety.

The same precepts of recognising and reducing power differentials, self-reflexivity, and conscious avoidance of a conflation of equity and sameness of treatment (often expressed as 'I just treat everyone the same') are central to a number of other approaches that are of similar pertinence to facilitating better Indigenous Australian engagement in mental health services. These include: cultural humility (Tervalon and Murray-Garcia 1998); the more nuanced and flexible models of cultural competence offered by Weaver (1999) (a model from a Native American perspective) and Goode and colleagues at the (US) National Center for Cultural Competence (Goode 2014); and the Australian-developed Integrated Model of Gabb and McDermott (2008). These approaches inform our comprehension of the minimum good practice requirements for effective cross-cultural service provision, yet their implementation holds major ramifications for individual practitioner training, organisational quality assurance, and overall service configuration.

At a pragmatic level, effective solutions will often be locally developed, and must be adequately staffed with appropriate funding models (Carey 2013a). Evaluation should be an ongoing and an inherent part of any programme with local knowledge and expertise being integral to the service (Carey 2013a). Issues of recruitment will be nuanced, so that it may be necessary to reconsider conventional employment position descriptions in order to employ the most appropriate staff. Early and ongoing community consultation will be an important facet of the continuity of the programme in order to ensure that the service being provided remains relevant to the needs of the community. Even the structure of interventions should be considered to avoid conflict with Indigenous communities' concepts of time, relationships and obligations, and the 'rhythm' of community life (Robinson and Tyler 2008). These may include not only culturally significant seasonal ceremonies but, also, the need to halt business as usual, upon a community death—sometimes for extended periods—for the conduct of 'sorry business'.

Good Practice Guidelines and Examples

Dudgeon et al. (2014) outline nine guiding principles, and they suggest that services that reflect these principles are more likely to be effective than those that do not. The principles were first articulated by Swan and Raphael (1995) and were adopted as the foundation of the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being 2004–2009* (Social Health Reference Group 2004). The nine principles are:

1. health as holistic, encompassing mental, physical, cultural, and spiritual health;
2. the right to self-determination;
3. the need for cultural understanding;
4. recognition that the experiences of trauma and loss have intergenerational effects;
5. recognition and respect of human rights;
6. recognition that racism, stigma, environmental adversity, and social disadvantage have negative impacts;
7. recognition of the centrality of family and kinship and the bonds of reciprocal affection, responsibility, and sharing;
8. recognition of individual and community cultural diversity; and
9. recognition of Indigenous strengths (Social Health Reference Group 2004, p. 6).

Services will more effectively engage, and offer scope for more effective outcomes, to the extent that Indigenous Australians are able to recognise these principles within the service.

Dudgeon et al. (2014) conducted a literature review of the academic and 'grey' literature to identify effective services. They located 49 studies describing 42 programmes or initiatives that provided information about service effectiveness in addressing a social and emotional well-being outcome for Indigenous Australians. From their review they developed several themes to enhance mental health programme and service delivery success:

- Indigenous participation in the design and delivery and evaluation of programmes;
- Working collaboratively with Indigenous services and the community;
- Initiating programmes to commit to being (and to demonstrate that they are) culturally appropriate, competent, and respectful of Indigenous culture;
- Having a strong capacity-building focus where knowledge, resources, and skills are shared and developed and Indigenous experience and knowledge are recognised;
- Working together with other (mainstream and Indigenous) services to support the delivery of a holistic and integrated programme or service;
- Fostering a culturally safe environment for programme participants;

- Flexibility—having structures and components that cater to local need;
- Enhancing existing services and resources to enable programme continuity; and
- Taking account of gender, family and kinship systems, language groups, and the involvement of community Elders in programme development and delivery (Dudgeon et al. 2014, p. 24).

Ensuring that mental health services reflect the principles and themes highlighted by Dudgeon et al. (2014) will be an important step for health service planners and service providers to take in order to improve the acceptability and effectiveness of services for Indigenous Australians. It is possible that adopting these themes and principles would also improve services for non-Indigenous Australians.

These principles and themes are complemented by other information, such as that provided by the Australian Indigenous HealthInfoNet (2014), regarding the way in which health services generally can be made more accessible for Indigenous Australians. The Indigenous HealthInfoNet suggests:

- Having Indigenous health workers on staff;
- Increasing the number of Indigenous people working in the health sector (doctors, dentists, nurses, etc.);
- Designing health promotion campaigns especially for Indigenous people;
- Having culturally competent non-Indigenous staff;
- Making important health services available in rural and remote locations (so Indigenous people living in rural and remote areas do not have to travel to cities, away from the support of their friends and families); and
- Funding health services so they are affordable for Indigenous people who might otherwise not be able to afford them (Australian Indigenous HealthInfoNet 2014).

Achieving some of the suggestions offered by HealthInfoNet would help to reduce the unacceptable disparity in health outcomes between Indigenous and non-Indigenous Australians.

Conclusion

Indigenous Australians are currently not engaging with appropriate and effective mental health services in ways that will enable them to enjoy the quality of life that they might wish for. This has more to do with the absence of widespread appropriate and effective services than it does with any lack of motivation on their part. Apart from the insecurely funded and over-stretched National Aboriginal Community Controlled Health Organisation (ACCHOs), there is a dearth of effective and sustainable services that take seriously the perspectives of Indigenous Australians and actively work to understand Indigenous experiences. To begin to address this situation, it will be necessary to hear what Indigenous people are saying with their words and their deeds—in Indigenous Australian terms, *Dadirri*, or *Ngara*, or *Yurringarnendi*: notions describing a sustained, situation-attuned, self-reflexive, and other-contemplative 'deep listening'—and to demonstrate that we have heard through a preparedness to work as equally contributing partners in the development of robust, ongoing, and effective solutions. If, indeed, addressing the social determinants of health is of particular pertinence to Indigenous Australian mental health and wellbeing—which would include not only those determinants of greater visibility, such as poverty and incarceration but, also, some less-apparent determinants, such as systemic racism, cultural continuity, and connection to country—then one approach might be to widen the mental health professional and service role. An adequate fulfilling of duty of care obligations, as well as promoting effective outcomes for Indigenous clients, would appear to mandate a 'public professional' role for both the professional and service—one of naked advocacy—in gaining non-health sector collaboration in addressing relevant determinants.

In some ways, the disparity between Indigenous and non-Indigenous Australians with respect to the incidence of mental health problems, along with mental health services, is symbolic of a global gap between high-income countries and low- and middle-income countries (LMICs). The global gap refers to the level of service provision that is required and the level that is available (White and Sashidharan 2014). At a global level, White and Sashidharan (2014) indicate a need for a greater consideration of the importance of culture and context with regard to the provision of services as well as a more balanced exchange of information between LMICs and high-income countries. Lessons learned, therefore, regarding the way in which mental health services can become more useful to Indigenous Australians will not only benefit the first nations of Australia but may provide important insights for other cultures as well.

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28

Language, Measurement, and Structural Violence: Global Mental Health Case Studies from Haiti and the Dominican Republic

Hunter M. Keys and Bonnie N. Kaiser

In this chapter, we draw on applied research from Haiti and the Dominican Republic to analyze three core concepts in Global Mental Health (GMH): the issue of language and communication in mental health research and service delivery; the challenge of measuring mental illness in cross-cultural settings; and finally, the need to recognize and address structural violence as the strongest driver of GMH disparities.

We begin the chapter with a discussion of language and GMH communication. Drawing on our field research in both settings, we describe how awareness of certain *idioms of distress* can be useful in recognizing, communicating about, and ultimately treating mental illness in non-Western contexts. We then discuss the benefits and limitations of universalist and particularistic (or relativist) approaches to measurement of mental illness, as well as methodological challenges. We argue for adopting a hybrid approach that utilizes both adaptation of standard psychiatric screening tools and development of local scales based on idioms of distress. Such an approach avoids the pitfalls that arise from assumptions of universality, while facilitating clinical and public health communication. We conclude the chapter by situating mental health disparities within the broader matrix of structural violence.

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Structural violence theory, as articulated by Paul Farmer (1996) and others, provides a critical lens to better understand mental illness in these settings because it traces mental illness back to its root causes: unjust institutionalized processes that produce and perpetuate disadvantage.

Our case study examples come from a series of interdisciplinary team graduate student projects conducted in Haiti (2010, 2011) and the Dominican Republic (2011, 2012). Beginning several months before the January 12, 2010, earthquake, we had partnered with Project Medishare, a local Haitian non-governmental organization (NGO), to plan exploratory research to understand how mental illness is experienced, communicated, and treated in Haiti's Central Plateau. This NGO was largely supported by Haitian national staff, ranging from community health workers to Haitian doctors and nurses who were obligated to complete a year of social service. Emory University had partnered with this NGO to provide funding and support short-term clinical services by visiting American students and professionals. In previous visits, student teams had noted that mental health needs seemed largely unaddressed or unexplored. The aftermath of the earthquake made this concern all the more pressing.

In the neighboring Dominican Republic, Emory University School of Nursing had partnered with a public, tertiary-care hospital in the Cibao Valley. There, the School of Nursing and Dominican partners conducted short-term mobile clinics in marginalized communities throughout the hospital's catchment area. During one of these visits, a team noted that little was known regarding the population of Haitian migrants who used the public hospital or their communities. The research discussed in this chapter derives from these established partnerships between an American university and local NGOs and healthcare centers. The research questions themselves regarding mental illness were developed in collaboration with these various research partners, and our findings draw on qualitative and quantitative data collected in both settings.

First, we should recall that the field of 'global health' emerged out of academic and policy circles in Western, industrialized countries. The health and disadvantage faced by people in poorer, non-Western settings became a subject of inquiry, advocacy, and 'intervention'. While this is a simplistic rendering, it points to the relationship between those who come from the industrialized 'global North' and arrive in settings of extreme poverty and hardship in the 'global South'.

When researchers from more privileged backgrounds arrive in settings where 'participants' are far less privileged, there are clearly many ethical challenges. In this chapter, we try to forefront both these challenges and our attempts to overcome them. For example, in Haiti, everyone speaks Kreyòl, a language that combines French words with syntax of multiple West African languages. French has long been the language of power in Haiti and remains the language of business and government, but it is only spoken by about 10% of the population. Though our research team included fluent French speakers, our training in Kreyòl and close collaboration with translators were essential to communicate with both Haitian professionals and community members. Furthermore, there were issues surrounding appropriate language specifically to explain the purpose of our research and the nature of the research questions. In Haiti, there is no universally understood term for the domain of health known as 'mental health'. Thus, even broaching the subject presents challenges in describing exactly what we as a research team were investigating.

Second, mental illness can be a highly stigmatizing form of suffering in many places, Haiti and the Dominican Republic included. Were we to inadvertently cast ourselves as 'the outsiders wanting to learn about "crazy people" (*fou*)', we could have unintentionally stigmatized community members we sought to interview or learn from. Furthermore, there was great potential for problems or misunderstandings to arise from power differentials between us as outsiders, the local professionals we worked alongside, and patients and community members. The history of both countries has long been marked by outside political influence, often exploitive; there is also a long history of intervention and humanitarian assistance, especially in Haiti. We had to remain sensitive to the ways in which our presence, attention, and involvement with some community members did or did not convey a sense of privilege not afforded to others. We had to clearly articulate what our purpose was, as well as what risks and benefit our research posed to community members. To do so, we worked closely with local partners and research assistants to conduct the research in an ethical, sensitive way. We had translators and cultural brokers in all interviews, and rather than conducting focus group discussions ourselves, we trained a local community healthcare coordinator to do so.

Language and Idioms of Distress

A central challenge in addressing GMH disparities is achieving successful communication between biomedical psychiatric categories and the constructs of mental distress employed by local populations. *Idioms of distress* are powerful communicative tools that convey forms of suffering embedded in particular ways of conceptualizing the world (Nichter 2010). Their use demonstrates not only how some groups of people communicate distress but also the ways in which they ascribe meaning to their illness experience. For example, Yarris (2014) describes how in Nicaragua *pensando mucho* (thinking too much) and *dolor de cerebro* (brain ache) are manifestations of the suffering that grandmother-caregivers feel in the absence of their migrant daughters. Beyond reflecting straightforward symptoms, these idioms indicate the ambivalence experienced by grandmothers, who rely on daughters' remittances yet feel that they are inadequate to make up for their lack of ability to achieve the moral and cultural ideals exemplified by having their family together. Additionally, research demonstrates how idioms of distress reflect particular ways of making sense of the self, personhood, and one's place in the broader world (Hinton et al. 2010; Kohrt and Hruschka 2010). In recognizing, the broader socio-cultural and meaning systems that are both reflected and embedded within idioms of distress, it becomes clear why they should not be considered reducible to psychiatry categories but considered in their own right.

From our perspective as Western, non-Haitian researchers interested in mental health, how do we even begin identifying these idioms? A first step consists of participant observation, combined with a sensitivity to issues of language. Our field experience in Haiti included much time in mobile clinics, where we collaborated with Haitian medical providers to diagnose and treat common medical problems among community members. Interestingly, we found that patients often expressed their complaints in reference to parts of the body, particularly the head (*tèt*) and heart (*kè*; Keys et al. 2012). One of the most common complaints of patients was 'my heart hurts' (*kè m fè mal*), typically diagnosed as acid reflux and treated with antacid medication. In addition to participant observation in these clinics, we also conducted semi-structured interviews with clinicians and community members, eliciting expressions and explanations of such phrases that appeared pertinent to mental illness. In these discussions, we found that 'my heart hurts' could signify complex emotional states, including grief and sadness. An earthquake survivor even used this expression when she recounted her story of profound loss. Thus, we found that 'head' and 'heart' complaints took on both physical and mental dimensions.

Why is it that—despite conveying multiple, complex meanings—these idioms were interpreted by Western-trained, Haitian biomedical providers as simply reflux disease, foregoing exploration of the complaint and providing symptom-relieving treatment? Multiple issues are at play in this dynamic. First, we should ask how rural Haitians regard a mobile clinic as a source for psychosocial care. In many of our interviews with clinicians and community members, it appeared that Haitians simultaneously draw on multiple sources of care for psychosocial complaints, such as religious and spiritual figures and other community-based structures (Khoury et al. 2012). Additionally, these idioms are inherently ambiguous. Thus, *kè m fè mal* as used in the mobile clinic may not, for this patient, explicitly reference feelings of sadness; the idiom may mean different things and be interpreted differently depending on context. Second, clinicians often told us that minimal training, coupled with the severe lack of treatment options—whether pharmaceuticals or referral to social workers or psychologists with another organization—left them with little choice but to forego exploration of these idioms. Many clinicians acknowledged that *kè m fè mal* can in fact represent sadness, but the conditions of such an austere clinical setting prevented them from determining if that was the case. With limited time to see many patients and lacking the ability to intervene in psychosocial needs, why even attempt diagnosis (Keys et al. 2012)? Finally, one could argue that such an emphasis on biomedical explanations on the part of Haitian clinicians in fact reflects how biomedicine in Haiti—first introduced through the French plantation aristocracy and later North American influences—continues to supplant local frameworks of disease, which include Vodou explanatory models (Lecomte and Raphaël 2010).

In the Dominican Republic, we found that idioms may also communicate broader experiences of injustice. In the Dominican Republic, Haitian migrants are a largely disadvantaged population owing to centuries of racism and overt anti-Haitian policies. As a result, many Haitian migrants report experiencing *imilyasyon* (humiliation; Keys et al. 2015). When prompted to explain what humiliation means to them, and what exactly causes it, many migrants reference the harmful, interpersonal interactions they have with Dominicans. In the workplace, many describe feeling humiliated when they are underpaid or assigned to menial tasks; in the general community, they may be victim to name-calling and harassment by immigration authorities. At the same time, a Haitian may feel humiliated by a fellow migrant, one who may have gained more material and social success in the Dominican Republic, or one who teams up with Dominicans to exploit other migrants. We will explore these issues of mental distress, social justice, and structural violence in more detail below.

Idioms of distress can thus provide a window onto the local world of those suffering from mental illness and provide a means to address mental health disparities in a culturally sensitive way (Kaiser et al. 2014). For example, there are practical benefits of identifying and incorporating idioms of distress into everyday clinical practice. A clinician in Haiti may explore in greater depth patients' complaints of head or heart pain and thereby potentially uncover broader psychosocial distress experienced by the service-user. Institutional changes can also facilitate such clinical communication. For example, Zanmi Lasante/Partners in Health, an NGO with a strong presence in this region of Haiti, has begun providing mental health mobile clinics in the region where we conducted our research (Grelotti et al. 2013). This care-giving format enables longer interactions than a typical mobile clinic, as well as evaluation by mental health specialists, both of which facilitate exploration of potential psychosocial needs. In addition to mobile clinics, Zanmi Lasante provides hospital-based mental healthcare and trains community mental health workers, all of which extends the provision of specifically mental healthcare and relieves the problems cited by clinicians as limiting their ability or motivation to explore idioms of distress in greater depth (Raviola et al. 2012, 2013). In fact, clinical and community-based mental health providers specifically incorporate idioms of distress like *kalkile twòp* (thinking too much) into their communication, alongside psychiatric terms like depression and anxiety, such as through the use of the locally validated Zanmi Lasante Depression Symptom Inventory (Rasmussen et al. 2015).

Beyond their use in clinical settings, idioms of distress could be folded into public awareness and education campaigns that tie into the broader push for policy reform. In the Dominican Republic, public health advocates could link the experience of humiliation felt by migrants to issues of racism, stigma, and discrimination. More fundamentally, recognizing the importance of idioms of distress imparts legitimacy to what the patient feels: no longer is 'heart pain' simply reflux disease; it may instead communicate sadness and grief resulting from either trauma or structural factors, including poverty and discrimination. Allowing the patient to share his or her own understanding of heart pain, or humiliation, empowers those who have long been powerless, a point that we will tie into our later discussion of structural violence and mental illness. Their complaints are given recognition in the context in which they are used, where social inequality, gender-based violence, and poverty are daily struggles.

Measurement

Challenges regarding mental health communication extend into the realm of measurement. Although it might seem that instruments aiming to assess mental illnesses are relatively apolitical and unproblematic, they in fact reflect the power structures that underlie diagnostic systems. For example, diagnostic and measurement tools privilege categorizations and symptom clusters developed within Western psychiatry (Kirmayer 2012), and we should recall that in its early days, Western psychiatry explicitly pathologized non-white, non-Western cultures, and ethnic groups (Littlewood and Dein 2000). Furthermore, uncritical cross-cultural application of these instruments reflects certain assumptions, such as the universality of mental illness and completeness of psychiatric symptom lists (Kleinman 1977). In contrast, much research has demonstrated variability in experience and manifestation of mental illness, and scholars argue that GMH research must move away from such strictly Western diagnostic systems (Summerfield 2008). Ultimately we must ask, to what extent can the instruments developed in Western settings be brought to bear on the detection and treatment of mental illness cross-culturally? Rather than adopting a strictly biomedical approach or completely disregarding the large evidence base of biomedical psychiatry, what balance can we strike between these two extremes?

Approaching cross-cultural measurement in GMH via translating standard tools can be thought of as a universalist approach. This contrasts with particularistic (or relativist) approaches, in which instruments are locally developed with the aim of capturing particularly local ways of experiencing and expressing mental illness (Weaver and Kaiser 2014). A universalist approach has the benefit of producing quantitative data regarding an internationally recognized set of diagnostic categories, which are assumed to be comparable across settings. Being able to draw on such data can be powerful to support arguments regarding relative burden and proposed response, including funding allocations. At the same time, this approach has been criticized as a form of biomedical imperialism, privileging psychiatric categories and ignoring local ways of experiencing and communicating distress (Summerfield 2008). Importantly, such approaches run the risk of failing to measure what they intend to measure, which undermines any attempts at cross-cultural comparison. For example, Kohrt and Hruschka (2010) argue that instruments attempting to assess post-traumatic stress disorder might in fact be getting at any number of things, including forms of stigma and suffering not at all related to trauma. Additionally, they note that word-for-word translation of some Western instruments has resulted in unintended, harmful effects among survey participants, who may be asked to respond to survey questions and select answer choices based on stigmatizing vocabulary.

In contrast, a particularistic approach has the benefit of ethnographic validity; in other words, we can be confident that what we are measuring is what we think we are measuring. Such approaches rely on local systems of communication, ways of understanding the world, and particular ways of experiencing and expressing mental distress (Weaver and Kaiser 2014). At the same time, by privileging the local to such an extent, it becomes difficult to achieve useful cross-cultural comparison, which is important in driving policy decisions and donor goals. Thus, while the particularistic approach has certain advantages, there must also be 're-translation', so to speak, of acquired data and research findings for monitoring and evaluation purposes and for audiences unfamiliar with the use of such methods.

Below, we describe several approaches to instrument development that have been used in Haiti that range from universalist to particularistic. We describe the varying strategies adopted to adapt or develop instruments and address the strengths and limitations of each. In particular, we highlight the methodological and epistemological shortcomings that remain with each approach—what can be considered the 'trade-offs' of selecting one method over another. We hope that these examples can guide decisions regarding measurement that effectively balance ethnographic validity with policy and intervention aims.

1. Adapting depression and anxiety measures

Our first example comes from our work in Haiti's Central Plateau, described earlier. As part of our exploratory qualitative work, we sought to develop measurement tools for common mental disorders, such as depression and anxiety. Recognizing the need to balance universalist and particularistic aims, we used a combination of adaptation of existing screening tools and development of local instruments to assess mental distress (the latter will be described below). We selected the Beck Depression Inventory (BDI) II and Beck Anxiety Inventory (BAI) due to their longstanding acceptance and use in Western clinical settings (Beck et al. 1996; Beck and Steer 1990).

We adopted the approach to cross-cultural instrument adaptation outlined by van Ommeren et al. (1999). The adaptation process begins with two rounds of translations by individuals: first, a lay bilingual individual translates all items, commenting on comprehensibility, acceptability, relevance, and completeness. Next, a bilingual professional—in our case, a Haitian doctor—adjusts any translations and likewise provides relevant comments according to the four categories above. The final step entails a series of focus group discussions with community members. For each item, we explored what might cause this experience, in order to understand whether it is conceptually equivalent locally. We then elicited alternate ways of discussing the same phenomenon that might be better understood locally. Finally, we asked whether each item was comprehensible, acceptable, and relevant.

Based on focus group discussions, we identified several problematic components of initial translations, which—without the insight gained from focus group discussions—might have led us to measure something other than intended (Kaiser et al. 2013). For example, the BDI item regarding loss of interest was initially translated directly, *pèdi enterese*. However, during focus group discussions, participants interpreted this item as referencing contexts in which one should not engage with others. Their understanding of 'loss of interest', as literally translated from English, seemed to relate more to social interactions and their appropriateness, rather than a more individually focused sensation that may reflect a core symptom of depression. Instead, we adjusted the item to *m pa sou sa* (literally, 'I'm not on it'), which better reflects the intent of the original English item.

Despite these adjustments to develop screening tools that were comprehensible, acceptable, relevant, and complete in comparison to the original tools, there remain shortcomings with the adapted versions. First, the BDI in particular is difficult to administer verbally, as items consist of multiple sentences among which participant must choose the most applicable to their experience. In administering the BDI in surveys, we found the tool to be cumbersome for participants. Additionally, despite efforts to ensure that items map onto local experiences, we nevertheless took as our starting point biomedical psychiatric categories. We thus recognized that we likely missed relevant experiences of mental distress.

2. Developing a local measure of idioms of distress

In response to this shortcoming, we simultaneously developed an instrument based on local idioms of distress, the Kreyòl Distress Idioms (KDI) (Kaiser et al. 2013; Kaiser et al. 2015a) screening tool, to be used in conjunction with the BDI and BAI. The aim of this tool was to assemble a collection of key expressions locally understood to communicate mental distress. First, drawing on our research team's interviews, focus group discussions, and participant observation, we identified 43 potentially meaningful idioms of distress to be considered for inclusion in a screening tool (Keys et al. 2012). Using interviews and a focus group discussion, we further explored these idioms, seeking to understand how they are understood and used in the communication of distress. We reduced the item set by removing idioms that used stigmatizing language or were redundant, poorly understood, or not specific to mental distress (Kaiser et al. 2013). After pilot-testing the KDI, we removed four more items that seemed to reference severe mental illness or used potentially stigmatizing language. The final tool was a 13-item instrument assessing mental distress.

There are several challenges inherent in this form of instrument development. First, the iterative approach used to develop it was very time-intensive, particularly compared to direct translation of screening tools. It is also possible that we tended to include those items that most stood out to us as unique to this setting, running the risk of privileging the 'exotic' rather than the most important or useful means of communicating and assessing distress. Using this methodology, we should recognize how our own values can 'creep' into the ways in which we analyze and interpret data, taking care to use safeguards such as inter-rater reliability, in which multiple co-investigators read the same texts and compare their interpretations. Even more important are efforts to work closely with local collaborators to ensure that interpretations are accurate and research foci are appropriate. Our interviews and focus group discussion that further explored potential idioms of distress we had identified were focused specifically on avoiding the risk of privileging the exotic.

Furthermore, by transforming idioms of distress—which communicate with a vast array of goals—into a tool for the identification of mental distress, we risked pathologizing normal reactions to circumstances of trauma, injustice, and structural violence. It is important to be aware of and try to minimize such problems in developing local screening tools. For example, our interviews and focus group discussions focused specifically on idioms of distress aimed to identify those considered locally to be most relevant to mental distress.

3. Developing a hybrid tool

A final approach to measurement likewise combines the goals of ethnographic validity and cross-cultural comparison. Here we describe the process used in the development and validation of a local screening tool for depression, the Zanmi Lasante Depression Symptom Inventory (ZLDSI) (Rasmussen et al. 2015). This tool was the result of a collaborative effort among Partners in Health—an American healthcare NGO—their local Haitian partner Zanmi Lasante, and research collaborators. It involved a series of steps, beginning with key informant interviews and pile sorts, during which participants categorized and described a range of potentially relevant items, in order to provide insight into their meaning and interrelatedness. The instrument developed based on these qualitative data included both rigorously reviewed items referencing depression symptomology and three idioms of distress from the KDI. Development was followed by a clinical validation process by mental health care providers, as well as iterative refinement of the tool based on its application in multiple hospitals and communities.

This approach yielded the only clinically validated tool among those discussed here, which also required the most extensive process of development and refinement. Comparison to clinical diagnosis is valuable for achieving construct validity, allowing more rigorous comparison to biomedical categories, and allowing for estimation of depression prevalence. At the same time, this approach necessarily privileges biomedical psychiatry diagnostic categories and requires the availability of professionals trained in it, which is often a shortcoming in GMH research (Bolton et al. 2002). In this case, the validation process involved all Haitian mental health professionals, largely familiar with the idioms of distress and conceptual categories adopted by their patients. Thus, this tool represents a hybrid approach that allows for cross-cultural comparison and prevalence estimation, while avoiding hegemonic displacement of local forms of meaning-making.

Strengths and Limitations of Measurement Tools

As indicated above, each of these approaches entails trade-offs. The rigorous adaptation process we employed with the BDI and BAI can effectively balance the goals of cross-cultural comparison and ethnographic validity, especially when used in tandem with a locally developed tool like the KDI. At the same time, the adaptation process is time-consuming, and ultimately the tools rely on categories of biomedical psychiatry. Development of a purely local screening tool best achieves the goal of ethnographic validity, ensuring that mental distress is assessed based on the concepts, categories, and means of communication that are meaningful and preferred. At the same time, this process is even more time-consuming, relies on in-depth qualitative research, and is less interpretable cross-culturally, including in communications with policymakers and donors. The ZLDSI balances the goals of cross-cultural comparison with ethnographic validity and is the only tool that is clinically validated. At the same time, qualitative data collection and clinical validation are time-consuming and require the availability of trained specialists. Finally, because clinical validation is in comparison to biomedical psychiatric constructs, categories developed in the West are necessarily privileged. This privileging of universalist over particularist approaches and of Western-derived psychiatric constructs over local categories, as well as potentially pathologizing normal responses to trauma and hardship all carry important implications for GMH research and practice.

Structural Violence and Mental Illness

One of the greatest lessons we have drawn from our experiences in Haiti and the Dominican Republic is that mental health disparities occur within broader systems of structural violence. Mental health research and service provision in low- and middle-income countries cannot stop at clinical treatment; there must be a concomitant effort to dismantle the institutional and structural arrangements that lead to suffering in the first place. To address this topic, we will present work in the Dominican Republic, where we investigated the mental health of Haitian migrant workers (Keys et al. 2015). Experience of Haitian migrants in the Dominican Republic illustrate how social, political, and historical spheres come together to perpetuate subjugation and suffering, mental illness being just one example.

Structural violence refers to broadly operating social, economic, and political forces that structure risk for death and disease (Farmer 1996). As a theoretical construct, structural violence explores why certain groups suffer more disease or disadvantage than others. Suffering takes myriad forms: from 'event-based' assaults such as torture or rape to more engrained, institutionalized forms of suffering such as racism and poverty (Farmer 1996). Structural violence acknowledges that suffering is diverse and is disproportionately spread across the human population. In the face of such complexity, however, structural violence traces this disproportionate burden of suffering back to the unjust institutional processes that create and perpetuate it. Indeed, those institutional-level processes can range from the economic arrangements that benefit some people over others, to social and political forces that confer greater power and standing to some groups, even to ways in which disadvantage itself is explained or talked about: how do our socioeconomic privilege and historical trajectory influence how we understand and explain other people's suffering?

Haitian migrants in the Dominican Republic, as well as Dominicans of Haitian descent, are familiar with disadvantage. To this day, the Dominican Republic, a country that originated from a Spanish colony, celebrates its independence from Haiti (won in 1844) rather than Spain (self-imposed annexation ended in 1865). This is a telling fact because it reveals how the Dominican Republic contrasts its national identity with that of Haiti's, instead more readily embracing the identity of its Spanish founders. The distinction goes beyond nationality, however. Race and racism are deeply implicated in the two countries' shared history as well and are embedded in the present-day experience of Haitian migrants.

When we consider how racism becomes institutionalized, the story of *anti-haitianismo* (anti-Haitianism) in the Dominican Republic provides a clear example. Dominican independence brought with it differentiation of one group from another: of one population defining itself in opposition to Haiti and all its negative tropes. This gave rise to attitudes among some Dominicans that Haitians are 'more African', have a different language, culture, and spirituality that is un-Christian and superstitious, and that they are determined to invade and conquer the entire island (Paulino 2006; Sagas 2000). In its most egregious form, anti-Haitianism was official State practice during the Trujillo dictatorship (1930–1961), culminating in the massacre of thousands of Haitians along the border region in 1937. The genocide has never been formally acknowledged as such by the Dominican government.

Anti-Haitian ideology differentiates Dominicans from Haitians on cultural and moral grounds and helps consolidate power over the Haitian and Haitian-descended minority in Dominican society. It is not only a *discourse* that moralizes against Haiti and Haitians but a political and economic *structure* that supports and justifies the exploitation of those minorities. The economic benefit of migrant workers from Haiti is well understood. In the early twentieth century, Haitian migrant workers were recruited en masse for work on sugar plantations, housed in *batey* communities, and employed as manual labor for a thriving economic sector in the country's early history (Martinez 1999). Over time, Haitian migrant workers, seeking to escape poverty, political turmoil, and structural violence in their home country, have sought opportunities in other industries as well, including construction, rice and cacao agriculture, and tourism. Today, there are an estimated 500,000 to 1.5 million Haitians and Haitian descendants in the Dominican Republic, the vast majority undocumented, many of whom have lived in the country for two or more generations (Canales et al. 2009).

One of the most apparent ways in which anti-Haitianism operates as structural violence is through widespread denial of authorized documents to Haitian migrants and their descendants, the periodic stripping of citizenship and legal rights of Dominicans of Haitian descent, and round-ups and forced expulsions of Haitians or 'Haitian-looking' persons. The laws surrounding documentation of migrant workers in the Dominican Republic, and their interpretation and enforcement, appear deliberately obfuscated in order to create an underclass of exploitable workers.

In many of our conversations with Haitian migrants, they describe the profound insecurity that comes from not having documents, of having them arbitrarily confiscated, and the fear and uncertainty that accompanies such a life (Keys et al. 2015). For example, one Haitian street market vendor recounted how immigration authorities may demand proof of documentation, which is then sold to another Haitian migrant. In other accounts, research participants expressed their frustration at the impossibility of completing all required steps, and paying all necessary fees, to acquire documents legally. Lack of documents constrains upward mobility in the job market, leaving most in menial, low-paying jobs and engendering fear of apprehension should they leave their communities, even for medical care (Leventhal 2014). They are unable to organize or petition for their human rights easily, and as such live in communities that lack basic services such as water and sanitation and workplace or living standards (Simmons 2010). In short, a policy and practice of 'non-documentation' further pushes this population to the fringes of society. Keeping an entire population undocumented thus represents a form of institutionalized anti-Haitianism.

To examine how mental illness relates to these forms of structural violence, we need only examine the stories and explanations provided by Haitian migrants themselves. *Imilyasyon* is something felt by an individual, often one in a very low-paying, unskilled job. More than likely, this individual does not have authorized documents. Consequently, this individual lives in an isolated community with other migrants, probably without basic infrastructure or access to healthcare. Interactions with Dominicans may involve daily insults such as name-calling or overt discrimination in markets, the workplace, or healthcare settings. All of this occurs alongside fear of apprehension and expulsion by Dominican authorities. Furthermore, in the face of such difficulty, this individual may feel a sense of failure to meet expectations of family back in Haiti, who are perhaps relying on this individual for remittances. In short, life is precarious.

Structural violence sits at the intersection of economic and social forces that simultaneously disparage and exploit the Haitian minority; it is the racist, nationalistic discourse that blames Haitian migrants and their descendants for their problems. Our research findings point to ways in which Dominican society arranges itself to create disadvantage among Haitians and their descendants. One obvious impact of that arrangement is the effect on mental health, including increased depression and anxiety symptoms, feelings of worthlessness and humiliation, uncertainty, and the perception that such hardships in life are unavoidable (Keys et al. 2015). Structural violence not only 'structures' the conditions in which many migrants live but also shapes how an individual perceives those conditions, to the point that suffering itself is assumed to be inevitable.

Meeting the Challenge of Global Mental Health Disparities

Acknowledging the role that structural violence plays in driving GMH disparities is a first step toward reducing them (Ecks and Sax 2005; Williams and Mohammed 2013; Patel 2015). Mental health of Haitian migrants in the Dominican Republic can be traced back to conditions set in place from unfair institutional practices, such as denying them authorized documentation, which in turn pushes migrants into lower socioeconomic positions and deprives them with a sense of control over one's life. Linked to this policy of unfair documentation is a history of anti-Haitianism, inherited from the legacy of slavery and Eurocentrism that privileged lighter skinned individuals with greater social status. Structural violence includes not only these broadly operating economic and political forces but also the everyday ways in which people conceptualize and explain health disparities. For some Dominican participants, the poor living conditions of many migrants, and their risk of waterborne diseases like cholera, were due in some degree to intrinsic character flaws found only among Haitians. In conversations with Haitian participants, however, we heard them link their suffering to lack of infrastructure and access to healthcare in their communities, as well as the hurtful interpersonal relations with Dominicans. In the end, many migrants felt powerless to change their circumstances, further compounding feelings of worthlessness and humiliation.

In the Dominican Republic, mental health of Haitian migrants is intricately bound to historical processes of differentiation, and especially anti-Haitian racism. Countering the institutional and interpersonal dynamics of anti-Haitianism requires a committed effort on multiple fronts. At the institutional level, there must be comprehensive reform of current documentation policies, so that migrants and their descendants can be brought into the larger fold of Dominican society. Equitable social and health policies should address longstanding service gaps in marginalized communities that include both migrants and poor Dominicans. Public education and awareness campaigns could also be implemented to challenge anti-Haitian discourse, inform the public of its harmful effect on mental health and well-being, and emphasize the two countries' shared customs and values. Such efforts would not be without challenges. Our field study was brief and exploratory in nature, and as such we did not have the time or data analysis completed to begin articulating these forms of intervention. At a minimum, our field project generated cross-cultural dialogue and awareness among both groups of each other's perspectives on these complicated issues. Our research was highly reflexive throughout the entirety of the project. As a team, we met to discuss findings as they emerged, and in so doing we engaged in self-criticism and reflection, culminating in several presentations at the local public hospital and university. Furthermore, we shared our perspective on anti-Haitian racism and the recent cholera outbreak in a joint letter published in Spanish (Keys et al. 2014). These discussions with audience members and as a team revealed how short-term field projects like ours could at least foster much-needed conversation, in both professional venues like peer-reviewed journals and public health fora, and in the communities where data collection occurs.

This 'community-level' experience that we shared as a research team can even be framed as a form of positive contact. 'Positive contact events' could assemble both Haitians and Dominicans; such gatherings have been shown in other settings to be effective at reducing prejudicial beliefs held by the dominant group (Pettigrew and Tropp 2006). In this way, global health research, particularly when it is community-based, participatory research (Foster et al. 2015), could serve as an intervention in itself. Positive contact events might gain better traction in these communities if they are modeled on the *konbit/convite* form of social collaboration. In Haiti, the *konbit* is a collective gathering of neighbors who join together to accomplish shared tasks; in the Dominican Republic, a similar structure is the *convite*. As evident in the shared etymological root of *konbit/convite*, Haitians and Dominicans may find that they share common cultural practices and values, and as such may find a productive and comfortable space to articulate ways of reaching greater social cohesion (Keys et al. 2015). This model of social collaboration may be particularly helpful in this setting, where social interactions between Haitians and Dominicans, and among Haitians themselves, appear to be a source largely of stress rather than support (Kaiser et al. 2015b). Such collaborations can hopefully provide a foundation for future intervention, research, and advocacy.

Conclusion

We have provided these case studies to illustrate three core areas of GMH: the issue of language and cross-cultural communication, challenges in cross-cultural measurement of mental illness, and the fundamental role that structural violence plays in driving mental illness. In our work and that of NGOs like Zanmi Lasante, we have witnessed the successful care provision that is facilitated by merging psychiatric and local conceptualizations of mental illness. In particular, we advocate for incorporating idioms of distress into clinical communication and using a hybrid universalist/particularist approach to measurement. We recognize too that ultimately, closing the mental health gap in low-resource settings becomes as much a political project as a health project (Mittelmark 2003). One way to engage in this political project and help steer GMH toward a more equitable future is to develop effective cross-cultural communication and measurement techniques and work toward dismantling the underlying economic, political, and social structures that perpetuate mental health disparities.

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29

Taking the Psychiatrist to School: The Development of a Dream-A-World Cultural Therapy Program for Behaviorally Disturbed and Academically Underperforming Primary School Children in Jamaica

Frederick W. Hickling

I started working in psychiatry in Jamaica in 1970. The legacy of 300 years of British slavery and colonialism that left an archaic 3000-bed lunatic asylum in a horrendous and appalling condition, and four trained psychiatrists for an island population of nearly two million, resulted in a devastating avalanche of adult mental illness. The neglect of mental illness of Jamaican children was an invisible problem in public discourse or consciousness, and the few psychiatrists of the period had no framework to link mental illness in adults to an antecedent matrix of mental pathology in children. This chapter will describe the development of *Dream-A-World Cultural Therapy* (DAW CT) and its variant *Dream-A-World Cultural Resilience* (DAW CR) from *psychohistoriographic cultural therapy* (PCT) that emerged after independence from British colonialism to address academically underachieving and behaviorally dysfunctional primary school children in Jamaica in an attempt to tackle the epidemic of transgressive and violent behavior in adolescents and young adults.

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The Origin of Psychohistoriographic Cultural Therapy

The challenge to psychiatrists and historians to work together for their mutual advancement (Jaspers 1923/1963) and to address the psychiatric impact of the historical legacy of slavery and colonialism led to the Jamaican psychiatric analytic methodology of *psychohistoriography* pioneered at the Bellevue Mental Hospital in 1978. Out of this has grown the fledgling discipline of PCT. The intervention incorporated the participation of patients, mental health staff and the community. The results revealed significant decreases in medication dosage, psychosocial disability scores, improvements in functioning and discharge rates of patients with long-standing severe mental illness (Hickling 1989). The process was born out of monthly large group meetings of staff and patients, called ethnohistorical meetings, which became the forum for an understanding of the history of psychiatry in Jamaica and the political dialectics of decolonization that the country was experiencing (Manley 1982). This novel therapeutic modality was combined in an eclectic manner with conventional psychopharmacology, and it was initially called *sociodrama* after the pioneering approach of Jacob Moreno (1946/1994).

Psychohistoriography is a neologistic word to describe a method of psychological analysis of group oral communications coined from *historiography*, the method of historical analysis that applies a dialectical exploration of published works and documented evidence from a particular period to determine social history. The new word was devised to create a link between psychology and history and to use historical data from the spoken word to cull social history. It was devised especially for use in societies where the oral tradition was the predominant method of communication (Brodber 1983). Starting with the training of a team of Assistant Nurses and Psychiatric Aides, the treatment paradigms of the existing conventional psychiatric attendants experienced a conversion into the creation of a Cultural Therapy team and the construction of a Cultural Therapy performance center at the mental hospital called the Bellevue Garden Theatre (Hickling 2004). The process was pivotal in the process of *psychological deinstitutionalization* (Whitley and Hickling 2007) used to sensitize the Jamaican population to the gradual closure of the mental hospital and in their preparation for the management of severe and enduring mental illness in the community.

The troubling concerns of widespread violence and mental disorders in Jamaica and the Caribbean encouraged the University of the West Indies (UWI) to establish the *Caribbean Institute of Mental Health and Substance Abuse* (CARIMENSA) in 2006 as a primary prevention institution aimed at exposing epidemiological connections and finding prophylactic solutions to

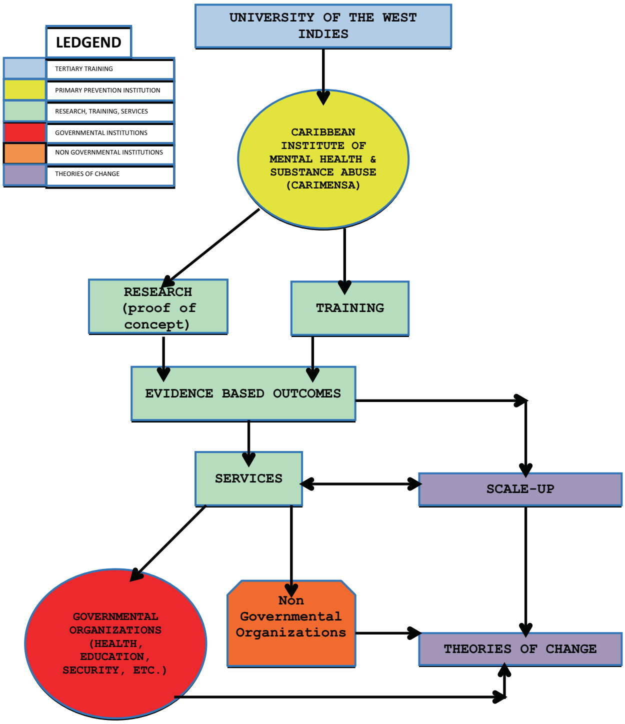

Fig. 29.1 Role of Primary Prevention Mental Health Institute (CARIMENSA)

these interconnected national problems (Fig. 29.1). The idea of primary prevention in mental health has been present for at least a century, but translating this interest into sustained effective action has been difficult (Durlak and Wells 1997). An unresolved question has been who should pay for primary prevention (Saraceno and Saxeno 2004), especially in low and lower middle-income countries. The UWI Vice Chancellor Rex Nettleford opined in 2007:

> The sanity displayed by the University of the West Indies in proposing the establishment of the Caribbean Institute of Mental health and Substance Abuse (CARIMENSA) … was an anticipated and arguably one of the most welcome bits of news for all who are committed to national growth and development. … It makes eminent sense that the kernel of the proposed Institute's operation should be a program of "Cultural Therapy" as the driving force in … delivering mental wellness … to the lingering consequences of a history, which, through slavery and colonialism has bred among many of the region's population feelings of self doubt, self-contempt, psychic disarray and turmoil. (p. v)

The CARIMENSA vision is to generate and facilitate the implementation of creative and innovative strategies to promote mental wellness, wealth creation and productivity at the individual and community levels. With seed funding from the UWI in 2005, CARIMENSA engaged in a private/public partnership with Psychotherapy Associates Ltd., a leading private medical research organization in Jamaica (Figueroa and Henry 1998) as a self-sustaining organization administratively positioned within the UWI but geographically locating itself in the Jamaican inner-city community. The principle objective of CARIMENSA was to link with governmental and non-governmental organizations to deliver evidence-based mental health therapeutic and health promotion research techniques, to dispense antidotes to social psychopathology and to establish research and training facilities to deliver scalable approaches for national workable outcomes (see chart 1). A training objective of CARIMENSA was to reschool psychiatrists and other mental health professionals in psychohistoriography, cultural therapy and other locally developed primary prevention therapeutic activities for both adults and children.

Perhaps the single most important objective of CARIMENSA is the initiation of a *theory of change*. This is 'a theory of how and why an initiative works' (Weiss 1995) or 'an on going process of reflection to explore change and how it happens' (James 2011). This produces a theory-driven approach to the design and evaluation of complex interventions in the development and evaluation of comprehensive community initiatives. Pawson and Tilley (1997) describe the commonality between social programs that are shaped by a *theory of change*, and *realistic evaluation* that always returns to core theories and interrogates their validity on the ground. The private–public collaboration of CARIMENSA with Psychotherapy Associates Ltd. has provided office and classroom facilities and administrative and community support, has facilitated the integration of trained mental health professionals with teachers and cultural therapists at primary and secondary school facilities, and has catalyzed *task-sharing* and *task-shifting* models between mental health professionals and other community workers and professionals. By encouraging private–public collaboration in mental health and facilitating the development and growth of mental health research and related publications, CARIMENSA has boosted the incorporation of mental health promotion as a *sine qua non* of clinical and administrative practice.

Mental Illness in Jamaican Children

There existed a profound disconnect between mental illness in adults and children by mental health professionals in Jamaica. The lack of comprehension of child mental health within the teaching profession and schools is also profound. In early postcolonial Jamaica, mental deficiency or obvious autism was the only recognized psychiatric condition in children. All other abnormally behaving children were classified as 'bad behaving pickney'.[1] Copious administration of flogging by the adult was the main treatment for this condition. Some teachers are still in total denial about the existence of mental illness in children. A Regional Education officer at a recent Cultural Therapy training conference in Kingston reported:

> I had a student who was clearly very psychotic and audibly hallucinating. When I told the teacher to send her to the nearby Child Guidance Clinic for treatment, the teacher responded '… *is just fool she ah fool you. She mek it up that she is hearing voices. Is jus bad de girl bad* …'. I could not convince her that the student was mentally ill even though she was obviously hallucinating.

The fourth edition of the American Psychiatric Association Diagnostic Statistical Manual (DSM 4th ed., text revision 2000) created a diagnostic condition called *Reactive Attachment Disorder* (RAD), which has been retained in the fifth edition published in 2013. RAD is a broad term intended to describe the sequelae of disturbed bonding before the age of four, which manifests as mood dysregulation, disturbed behavior including anxiety, aggression and inhibition, as well as aberrant social relationships (Becker-Weidman 2009). These early childhood wounds result in problematic social expectations and behaviors that leave lifelong vulnerabilities in evident social disturbances and problems with intimacy or family relationships. These traumas are often apparent where there are frequent changes of caregivers, lack of any stable primary caregivers or lack of caregiver's responsiveness to children's needs (Ainsworth et al. 1978). More recently, Cook et al. (2005) and Balbernie (2010) and others have proposed to substitute the term '*Complex Trauma*' for RAD. Guzder et al. (1996) reported that high-risk children with borderline pathology had histories of higher rates of physical abuse, sexual abuse, severe neglect, as well as family breakdown and parental criminality. These children usually presented with disruptive disorders or oppositional behaviors and were highly comorbid with conduct disorder. A recent longitudinal RCT in the USA of 891 children with conduct disorder revealed that nearly 70% displayed one internalizing, externalizing or substance abuse psychiatric problem at age 25 (Dodge et al. 2015), suggesting that adult depression, personality disorders, post-traumatic stress disorders, dissociative disorders, somatization, self-harming behavior and eating disorders have their roots in attachment disruptions and childhood trauma.

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[1] '*pickney*'—Jamaican dialect = child(ren).

Other studies in the USA report that diminished intellectual ability and academic failure have also been associated with aggressive behaviors developed by age eight (Huesmann et al. 1987). Bullying, attacks on teachers, threatening behaviors, oppositional defiant behaviors and sexual acting out are markers for high risk for conduct disorder, personality disorder, substance abuse and school dropout (Hunter 2014). Disruptive symptoms in early childhood are unlikely to change without therapeutic interventions and may be prodromal signs of long-term mental health problems (Domitrovich and Greenberg 2003; Esser et al. 1989). These findings were instrumental in determining the direction and prioritization of our DAW CT interventions for eight-year-old primary school children.

Crawford-Brown (1999) confirmed the importance of neglect in childhood as a risk factor for conduct disorder in Jamaica associated with aggression. Many inner-city children in Jamaica have experienced societal and domestic violence, sexual and substance abuse, absent fathers and attachment disruptions (Samms-Vaughan et al. 2005). Many have also experienced poor nutrition, poor housing, substandard education and an inordinately high rate of conduct disorder and school dropout. Crime, and aggressive and delinquent behaviors were associated with significant underachievement, exposure to violence, use of drugs or alcohol and suicidal thoughts (Sams-Vaughan et al. 2005). Family conflict was identified as a strong predictor of boys' aggression in Jamaica (Meeks Gardner et al. 2003).

Most instances of lethal violence in Jamaica occur in the inner-city garrison communities of Kingston metropolitan area[2] (Harriott et al. 2004; Lemard and Hemenway 2006). Figueroa and Sives (2002) described the development of the garrison constituency in Jamaica as a unique postcolonial feature of the Jamaican political system. Children and young people are drawn into gang and turf war simply because they are from a particular garrison community (Milbourne et al. 2005). Ruled by strong-arm gang leaders called 'dons', these garrisons shape the macho concept of manhood held by young males that is synonymous with the use of firearms. Single parent working mothers, like other adults, are often intimidated and dominated by the dons and their youthful 'soldiers'. These young women look to these men and boys for protection and yield to their sexual demands. Adolescent pregnancy continues to be a major public health challenge in Jamaica with the related trend of increasing numbers of adolescent girls infected with HIV (UNICEF 2008).

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[2] A garrison constituency is a political stronghold in which the electoral process and any significant social, political, economic or cultural development can only take place with the tacit approval of the leadership of the dominant party.

Absent fathering in the psyche of both the family and the children has been another blind spot in Jamaican cultural reality. Anthropologist Herbert Gayle (2014) identified that there was zero presence of the father in Black families in Jamaica in 1838, and although this presence had grown to 15–18% by the time of the first election in Jamaica in 1944 and to 37% in 2001, the current rate is only 42%. Awareness of behavioral problems such as poor anger management, conflict and scant regard for discipline and authority in Jamaican children in and out of schools has mushroomed into a constant public preoccupation in recent times (Hill 2014).

Child Mental Health System in Jamaica

Jamaica's Ministry of Health controls the overall delivery of mental health services. Child and adolescent services are provided at child guidance clinics across the country. However, although they are staffed by a dedicated group of professionals working in difficult circumstances, these do not meet the population's needs (McKenzie 2008). By early 2000, the Jamaican Government introduced guidance counselors—qualified teachers who have received additional training in psychology and social work—in the school systems to help to stem the tide of the many social problems being experienced by primary and secondary school students across the country (Palmer et al. 2012).

Dream-A-World Cultural Therapy Pilot Project

The use of culture as an instrument for education, consciousness raising and demystification, as well as entertainment is a tool that the peoples of the world have been using in the struggle for freedom, land and better working conditions for centuries. It has been rediscovered and titled 'people's (or popular) theater' in recent years and combines the use of dialect, folk poetry, drama, dance, music and song to mobilize people to utilize their creative cultural energy in the struggle against racism and oppression and in the fight for rights, justice and better conditions. Ross Kidd (1980) described the process as

> the people's medium, drawing on their skills and creativity, expressing their concerns and analysis … (and) reinforces the growth of identity and self confidence, and must mirror reality. (p. 10)

Paulo Freire (1972, 1995) emphasized the idea of education as cultural action and the liberation from oppression requiring collective struggle. He suggested that the transformation of any society requires the development of revolutionary consciousness and the mobilization of a culture of creativity. An art-based pedagogical Jamaican case study called the Area Youth Foundation[3] led by Sheila Graham, who had been trained in the Freire's dialogic methodology, demonstrated this method in achieving outcomes for the group of thoughtful collaboration leading to conscientization in terms of deep reflection on their lives for decolonizing education and society (Hickling-Hudson 2014).

A multi-modal risk-reduction pilot study, rooted in PCT, was mounted by CARIMENSA for at-risk eight-year-olds from inner-city Kingston in a community mental health center located within walking distance of their school. In 2006, CARIMENSA employed Sheila Graham to help implement the 'Dream-A-World Cultural Therapy' program.

> Using large group psychotherapeutic ethnography … as the central and pivotal psychological activity … with the children in a large group circle, and the daily discussions, designed to capture the children's attention, helped them to concentrate collectively on one topic at a time, and to understand the importance of group socialization. The psychotherapeutic objective was to provide a psychological catalyst that would help to transform their behaviour by repositioning their thoughts and their emotions from the realities of their world and their consciousness, into a reconstructed, re-engineered psychological reality of their own creation. (Graham et al. 2007, p. 54)

The essential element of 'Cultural Therapy' (Hickling 2007) is the psychological analytic process of *psychohistoriography*, and a series of activities comprising *centering*—incorporating relaxation techniques such as deep breathing, calisthenics and performing arts' warm-up routines, and *circling* (using the circle as the principle formation for teaching and communication) for psychotherapeutic group discussions to stimulate children to critically evaluate their world. A third component called *culturing* allows the children to freely catalyze their thoughts into artistic modalities of music, dance, art and drama. By weaving the products of their creative imagination into *Show and Tell* performances, the children are enabled to negate complex trauma by catalyzing creativity. The goals of the innovation were to promote resilience, to increase academic performance, to increase self-control and modify maladaptive behaviors, to increase self-esteem and wholesome identity formation and to increase the creativity and productivity of high-risk primary school children. Three teachers selected 30 cohort children with conduct and behavioral

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[3] Area Youth Foundation (AYF) is a charitable, non-governmental organization which, since 1997, has been working with young people in the inner cities to assist them in developing additional life skills and business training. AYF often uses an arts-based approach and focuses on building bridges of friendship between the divided, marginalized communities of Kingston' (http://www.areayouthfoundation.com/).

problems and 30 control children matched for age, gender and social class. The cohort and controls were all selected from the group of students who were performing in the bottom 25 percentile of the transitioning Grade 3 who would be advancing into Grade 4 in September of 2006. The risk factors of the selected cohort included poor performance in literacy and numeracy coupled with behavioral factors such as aggression, hyperactivity and lack of motivation. The cohort and the controls were selected exclusively by teachers using the cultural nosology of the 'bad behaving pickney' and not on the assessment of a psychologist or psychiatrist (Box 29.1).

Box 29.1 Examples of Children Enrolled in Allman Town DAW CT intervention

Jimmy: A nine-year-old boy of rural origin who had witnessed the murder at age seven years of both his parents had run away from home and was living 'rough' in the bushes in the country. He eventually got to his grandmother in Kingston who adopted him. He was virtually uncontrollable in class, exhibiting disruptive behavior, constantly fighting other children, and unable to read or write.

Mary: One of 13 siblings. A neighbor noticed that she was not going to school. With her mother's permission, the child was taken and enrolled in school. The child's birth was registered, and the school enrolled her in Grade 2. She could not read at that time, and two years later (in Grade 4 at nine years old) she was still barely reading.

Some conditions that these children faced were overcrowded classrooms, overcrowded or substandard housing, poor nutrition, unstable families, absent fathers, low self-esteem, low expectations and ever present threat and fear of violence. Parental consent was obtained for the program, and although the parents' participation was not required, they were invited at regular intervals to observe the progress and performance of their children. The intervention consisted of a three-week 40-hour summer program. The children were encouraged to participate in a process that intended to 'Dream-A-World' (DAW). This involved children imagining and imaging things outside of their day-to-day experience. They were challenged to imagine that they had the power to create a whole new world on another planet, to name it, to conceive the flora and fauna, decide what they wanted to take from this world to the new one and what they wanted to leave behind, imagining their life on a new planet with a new social, ecological world of settings and animals they wished to live with. The most significant outcome of this exercise was getting the children to articulate their clear ideas of good and bad, right and wrong. They showed a clear appreciation of the things that were negative and positive in their lives, and it was clear that they wanted to leave behind the negatives.

They valued the beautiful things of nature to which they had little exposure in their inner-city environment. They appreciated the things that engendered love, kindness and enjoyment and rejected the things that engendered fear and led to violence and abuse. They wanted to take things that were beautiful, that were gentle and the things that were life supporting. They were very clear that they didn't want things like using foul or abusive language even if they themselves used such language, but what they were saying was that 'even if we do these things, we know that they are bad and we don't want them'.

The theory of change behind this approach emerged from the realization of:

> The after-shocks and consequences of enslavement, emancipation and colonial domination (…). (Smith 2014, p. 2)

… on the mental health of contemporary Caribbean societies.Linking the high levels of transgressive behavior and personality disorder reported in Jamaica (Hickling and Walcot 2013) with the international finding that children who were not reading by age eight years were associated with aggressive and dysfunctional behavior in adolescence and adulthood (Huesmann et al. 1987), the therapeutic approach had to be shifted to strengthening the child's internalizing behavior in an environment of fractured parental attachment and dysfunctional fragmented families and promoting resilience (Robertson-Hickling et al. 2009). This vision was based on the evidence that children in discordant and disadvantaged homes are more likely to demonstrate resilient characteristics if they attend schools that have good academic records and attentive, caring teachers (Rutter 1984).

The DAW CT strategy clarified the role of the cultural therapist who worked to create visionary ways in which psychological challenges can be identified, allowing the children to reflect on their life and their society. Over the course of the DAW CT intervention, the cultural therapists explored the *psychological contradictions* of children by embedding these in the popular culture to stimulate the imagination to provide limitless scope for invention and change. The children created songs, poems and dances about their world to construct a dramatic performance, later presented to parents, teachers and guests on the final day of each workshop (see Box 29.2). This engagement elicited narrative building and social skills engagement as they cooperated to share and interact with group work. Two-hour follow-up workshops were held fortnightly during the school terms for three years of the program which allowed a 'refueling' of the basic social skills, nurturing, holding and literacy components over this period.

Box 29.2 Example of Poem Created by a Child Enrolled in the Intervention

Timmy: Timmy, who was not reading at his age level, was described by the teacher as one of the ‘sad boys’: ‘He was just plain lazy. If you even ask him what’s his name you have to be like. … “What did you say?” That’s just him … a very sweet child, with a nice personality. … He created the poem “The Bad Crew”’.

One day I was walking with my friends
and I saw a group of bad boys.
They were a crew.
The group was walking with a gun.
They shot a man and took away his money and credit card.
The police arrived, saw the boys and took them to the station.
When the bad crew was walking with the police
one of the boys escaped.
He ran away when he was taking the picture.
The police called for back up and they saw the man run into the bushes,
get away with all the man’s money.
That was all about the bad crew.
When you follow bad company they lead you astray.

Several of the children selected for the intervention did not know how to relate to other children without fighting. Almost all the children had symptoms of very poor attention span and hyperactivity. Most of these children were unable to concentrate or focus on tasks over a sustained period of time, and their attention would drift very quickly.

The intervention DAW CT program was evaluated using the Achenbach System of Empirically Based Assessment Teacher Report Form (ASEBA TRF) (Achenbach and Rescorla 2001) and end of term grades for the intervention group compared to matched controls who were offered usual school supports (Guzder et al. 2013). Changes in academic performance were measured using the children’s grades for language, art, mathematics, science, and social studies, obtained at the end of each academic year. All 30 children from the ‘proof of concept’ pilot project failing the Grade 3 Primary School Test and exhibiting severe disruptive disorders had passed the Grade 6 Achievement Test 36 months later, and they entered accredited High Schools. The intervention cohort made significant improvements in school social and behavior adjustment measured by the ASEBA TRF. There were 17 (57%) boys and 13 (43%) girls with a mean age of 9.1 years (SD = 0.41) at the start of the program. Full details of the statistical analyses performed in the study are available in the paper by Guzder et al. (2013). At end of the intervention, the study group children had significantly lower scores for aggressive behaviors and oppositional defiant behavior. This was supported by significant within-group improvements in ratings of aggressive behaviors ($p = 0.035$), oppositional defiant and conduct problems ($p = 0.027$), and academic performance and learning ($p = 0.026$). There were no significant within-group changes for the control group. Within-group improvements in teacher ratings were found for the study group boys on their academic performance, learning, and behaving, rule-breaking behavior, aggressive behavior and oppositional defiant and conduct problems. By the end, the boys received significantly better teacher ratings of their academic performance and their behavior. There were no significant within-group changes for the boys in the control group. Within the study group, the F statistic found strong evidence of differences in the mean of language scores across the four assessment times, which was not the case for the control group. Post hoc regression estimates for study group showed regression coefficients relative to the final testing in 2009 to be significantly less in 2006 and 2008 suggesting improvements in scores over the four-year period, although it was not significant in 2007. Change in mean differences in mathematics ($p < 0.001$) and science scores ($p < 0.001$) was found for both groups across the four assessment times (Box 29.3).

Box 29.3 Case study of Child Enrolled in Intervention

Andrew: Living with his mother in a violence-prone inner-city community, he was initially very quiet and communicated little. '*Before DREAM-A-WORLD mi just shy but afta … mi kinda … it bruk mi outta dat … it was a place we come and interact with each other, learn new activities, get better at what we could do, like how we draw and ting … mi always like art from basic school coming up*'. After the DAW program he passed the GST Exam, went to a traditional high school, and after five years he passed seven out of eight Caribbean Examination Council school leaving subjects. He is presently in Sixth Form studying art, business and computer studies. He would like to become a professional artist or an accountant, as he is good at business studies.

The three-week summer DAW CT interventions produced artistic creations—paintings, papier-mache masks and costumes—from each child and produced a ten-minute dramatic performance from each school reflecting original music, songs and performances of all the participants from that school, mirroring the thematic concept of the DAW CT activity which reflected the 'new planet' that they had imagined, with the aspects of life that they wished to keep and the aspects of life that they wished to discard.

This intervention was especially successful for the boys who achieved behavioral and academic gains (Guzder et al. 2013). The girls did not make comparable statistically significant improvements. Two factors in particular were suggested to having contributed to this. The first related to a stronger therapeutic bonding relationship between the boys and the two older male music therapists on the DAW CT program. Secondly, it was suggested that the powerful female cultural bonding systems in young Jamaican females reinforce conventional psychosocial patterns of behavior in young inner-city Jamaican women. Both hypotheses are untested and require future exploration.

The Dream-A-World Cultural Therapy Scale-up Project

The DAW CT proof of concept was completed in 2009. Publication of the results soon attracted attention for a scale-up project, which was funded by Grand Challenges Canada (GCC). Launched in May 2013, it consisted of two components, one focusing on the youth (DAW CT) and the other concerned with adults (Community Engagement CT). The scale-up three-week summer DAW CT workshop was established in July 2013 in four Jamaican inner-city primary schools. A group of 100 primary school children aged 8–9 years in Grade 3 selected by their teachers on their poor academic performance and/or disruptive behaviors were compared with 100 controls matched on age, gender and performance. Both groups are currently being followed until August 2015, with the intention of providing evidence-based scale-up and training-the-trainers data for improving the scholastic and behavioral performance of the entire primary school population of Jamaica. The study will conduct realist evaluation and synthesis (Pawson and Tilley 1997) of the ‘theory of change’ based on promoting resilience (Robertson-Hickling et al. 2009). During the course of the two years of this DAW CT arm of the GCC project, the children have been attending 20 bimonthly cultural therapy sessions led by the CARIMENSA training team, going on field trips to environmental recreational spaces outside of their sheltered violence ridden communities and participating in three consecutive summer workshops. All these activities have been videotaped and will be analyzed using AtlasTi software using grounded theory techniques. All the artwork produced by the children will be photographed and cataloged. At the beginning and the end of each summer workshop, the teachers and the CARIMENSA team participated in focus groups that were also videotaped, and the transcriptions of these were analyzed using AtlasTi software. The transcription analyses of the recorded material are currently being used to unpack the methodological interventions used by the DAW CT activities, the conversations and reactions of the children and the teachers and the cultural therapists, which in turn are being used to develop hermeneutic trees for the preparation of academic materials and training manuals. Twenty months into the project has already produced nine focus groups, led by the GCC principal investigators and consultant collaborators, and over 650 video tapes of activities and outcomes of the program that are being used to test and refine the initial theory of change. The following are quotes from focus groups held with teachers after the completion of the first DAW CT summer workshop in 2013:

Teacher #1:

> Some of them [the children] could not spell things as simple as their names. But then at the end of the [DAW CT] program they were writing the names of their school; they were writing their own names clearly.

Teacher #2:

> There was a boy in class … there was something wrong with him. The formal school setting could not help that child. After the [DAW CT] drama … I saw a side to him I didn't see before. He was there acting; doing his part. I was amazed.

Each school was required to imagine and name a planet in their DAW solar system and to create poems and artwork to represent the qualities and inhabitants of their new fantasy world. A song (and associated pieces of the artwork) created by the children of *Balmagie Primary School*, who named their fantasy planet *Esca Sonar,* are included below (Box 29.4).

Box 29.4 Song Created by Children at *Balmagie Primary School*

Balmagie Primary School Fantasy Planet Esca Sonar Song
I've got a ticket for the long way round
To Esca Sonar all the way
And we sure would like your sweet company
We're leaving tomorrow what do you say?
Chorus
Esca Sonar, Esca Sonar
We're gonna go to Esca now
I gotta tell you it's a good, good place to spend your day, oh
We're gonna go to Esca now
I've got a ticket for the long way round
To Esca Sonar all the way
It's got chocolate
It's got heroes
It's got mansions we have zeroes
'Cause we even have a money tree

Photograph 1

WELCOME TO ESCA SONAR

A Good, Good Place to Spend your Day

We have:

Peace

MONEY TREES

Chocolate

Pretty Houses / MANSIONS

Super Heroes / Heroines

We have no:

Violence | Crimes | wars | Gunmen

Cursing | Quarelling

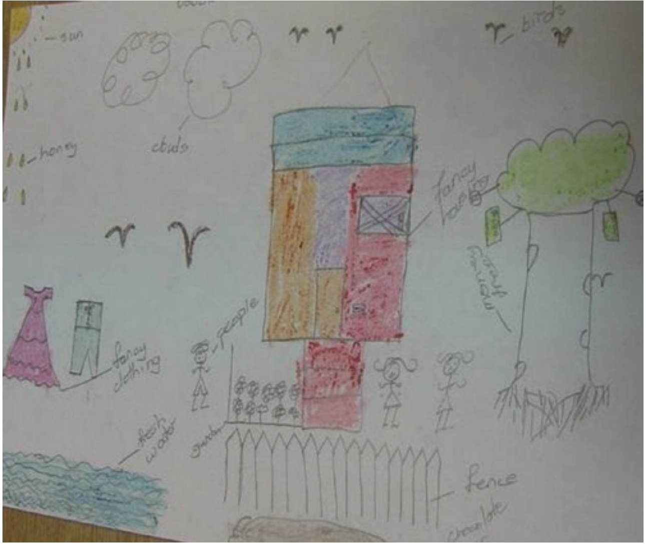
Deaths

Diseases

Pollution

Photograph 2

Photograph 3



It was extremely difficult to get parents to participate at the beginning of the program, as some reported that whenever they were called to the school about their child it was usually related to the child's bad behavior and some negative school report. As the children began making progress the parents reported observing improvements in their children at home and were delighted at their positive improvement at school. After the first Show and Tell activity in 2013, a parent reported:

Case Study:

> My nine-year old son was constantly on the street mixing with 'bad company', and could not read or write … since the beginning of the Dream-A-World program he is reading and is staying at home more. He takes part in family activities, watching TV with us. … I was amazed to see his dance performance at the Show and Tell today.

There has been significant increase in parental engagement in the school life of their children since the onset of the DAW CT program (Guzder et al. 2013). The Principals also reported increased task-sharing and task-shifting skills between teachers in the management of educational and behavioral difficulties in the children in their schools.

Dream-A-World Cultural Resilience Transition to Scale in 35 Schools

The *Dream-A-World Cultural Therapy* (DAW CT) model metamorphosed from the proof of concept and scale-up programs into the *Dream-A-World Cultural Resiliency* (DAW CR) model in 35 failing primary schools selected by the Ministry of Education. The academic and cultural therapy components of the DAW CR program are identical to those used in the DAW CT model. However, the program schedule was modified for the specially identified and selected children with academic and behavioral challenges to be carried out in a specially created parallel Grade 4 Class in each participating school. Whereas the DAW CT program was a 240-hour program constituted over two years with three summer-holiday workshops, the DAW CR program is a 1000-hour program spanning a regular school year. The assigned teacher and guidance counselor conducts the scheduled academic and cultural therapy sessions with these children on a daily basis.

This transition to scale project was initiated in August 2014 with training programs for 80 primary school teachers, guidance counselors and Educational Officers by the CARIMENSA team of cultural therapists and creative arts professionals. Once the program is initiated by the teachers and guidance counselors in the specially created parallel Grade 4 Class, a core team consisting of three cultural therapists then visits each school monthly to provide supervision and support for the program and to establish outcome data collection programs using ASEBA for analysis and evaluation of behavioral and academic achievement over the year's activity. The evidence thus far indicates that the *Dream-A-World Cultural Resiliency* program provides behavioral and academic advancement for the selected students similar to the DAW CT programs. The DAW CR also acts as a transforming catalyst for other teachers in the primary schools on overall school performance, as well as the parents and communities surrounding the school. The reported and videotaped evidence collected suggests that the engagement and passion of the teachers selected and trained in this DAW CR activity has not only helped to transform the underperforming and dysfunctional children but has also helped to catalyze and facilitate a metamorphosis of their primary school culture through a change in the approach of the other teachers on the basis of the task-sharing and task-shifting component for the wider school population.

Although the majority of Jamaican children and adolescents are well adjusted, a substantial group exhibits high levels of maladjustment and deficient functioning. At present there is a 40% contingent of primary school graduates to high schools across Jamaica annually who are functionally illiterate and behaviorally dysfunctional, and who form the nidus of criminal and transgressive behavior in present-day society (Williams n.d.). The DAW CR model is designed to transform the dysfunctional underperforming cohort each year in primary Schools across the country into literate and productive adolescents, thereby reducing antisocial behavior in schools and among adolescents in Jamaica. The theory of change envisions that a literate and functional population will translate into reduced crime and social violence and increased economic productivity (Fig. 29.2).

Transition to Scale

The pathway to scale for the DAW CT project has been designed to progressively morph from 1 to 4 schools, then into a DAW CR program in 35 schools, then to 350 schools and finally to 1000 schools over a three-year period. Although funding for this process has not yet been established, the interest being shown by the Jamaican Government and a number of international agencies generates a degree of optimism. The CARIMENSA collaboration with public and private sector organizations has been instrumental in

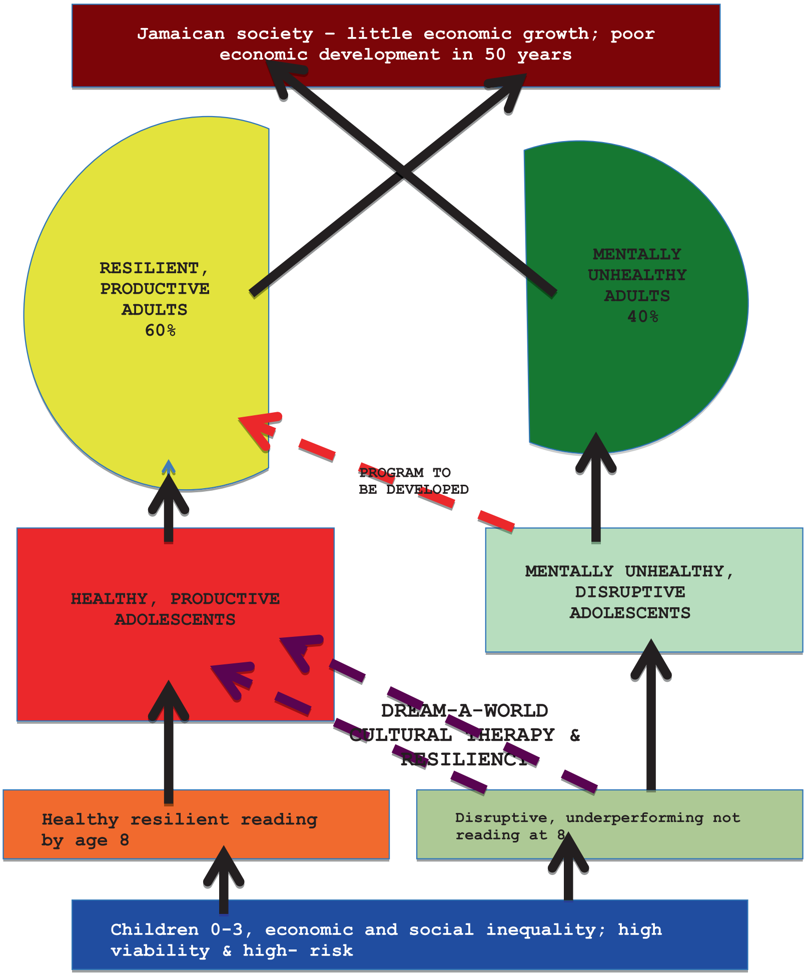


Fig. 29.2 Jamaican Life-cycle Developmental Map

overcoming challenges such as funding, political resistance and community acceptance of the innovation.

Cultural Engagement—The Adult Arm of the Psychohistoriographic Cultural Therapy Program

The pernicious psychological sequelae of slavery and colonialism on the Jamaican people have engendered the need for a systematic social reengineering program for the country to overcome the damaging outcomes.

Post-independence creative public policy has established an island-wide community mental health service (Hickling 1995; McKenzie 2008) and PCT (Hickling 2007) intervention as social reengineering tools that have impacted the Jamaican mental health landscape. The development of a Cultural Therapy Team and Garden Theatre Center in Bellevue Hospital in 1977 had a powerful influence on the hospital, the surrounding inner-city communities and the entire country (Hickling 1989, 2004).

The adult arm of the GCC-funded intervention aims to reestablish the efficacy of the PCT intervention in decreasing violence in an inner-city community in Jamaica. Using a case-control study design, PCT will be evaluated in Seaview Gardens Health Center (SGHC) in inner-city Kingston. This community has high unemployment, very low income, high levels of interpersonal violence and escalating crime rates. At SGHC, a primary care clinic offering services to the community in all specialties of public health and a team of mental health professionals led by a psychiatrist have been responsible for implementing the Community Engagement Cultural Therapy (CECT) program. During 30 months, patients from all of the public health specialties and other members of the Seaview Gardens community will create a Cultural Centre located in the existing community health center. Also, the Community Engagement Mental Health Team (CEMH) will engage in weekly PCT meetings and activities conducted by the mental health team. Focusing on wellness, the CEMH is engaging all persons at the clinic, those with physical and mental ill health, as well as those who are not employed, creating facilities for them to develop productive skills in a social rehabilitation program. The project is following the outcome of the CECT intervention for the period. A range of measurable mental health outcomes, including assessment of domestic and interpersonal violence, job creation and poverty reduction, as well as degree of community engagement and participation will be assessed and reported. The potential for sustainability and scale up through the sharing of techniques learned has been insightful.

Many variants of PCT including DAW CT, DAW CR and CECT are discussed in this chapter. The current work is enabling the writing and publication of the qualitative and quantitative data characterizing these processes so that the models can be replicated and practiced not only in Jamaica but also in other areas of the world. The creation of manuals will also assist in the design of policy recommendations for the incorporation of the variant models of Cultural Therapy in the school curriculum and mental health services in Jamaica and worldwide. The DAW CT project has had success and gained attention in both international and local circles. Internationally, the pilot DAW CT project won the 'Turning The World Upside Down' competition in London in November 2013 established by Lord Nigel Crisp to recognize mental health innovations in low-income settings (Centre for Global Mental Health, 2013). The success of the DAW CT and the scale up internationally has led to a Global Mental Health (GMH) discourse about DAW CT via social media and local programming (Centre for Global Mental Health 2013, McGrath 2014). The GMH conversation aimed at achieving equity in mental health for all people worldwide (Patel and Prince 2010) has generated questions about its current goals and consequences (Kirmayer and Pedersen 2014) and has been critically challenged by Summerfield (2013) and White and Sashidharan (2014) as being synonymous with medical imperialism. The suggestion that this Jamaican initiative is an example of 'counterflows' of mental health knowledge originating in low- and middle-income countries that could influence practice in high-income countries has been advanced by White et al. (2014) to encourage reciprocity in the current discourse on GMH.

The 'Dream-A-World' project has successfully taken the psychiatrist and the mental health team out of the office and the clinic, and it has placed mental health squarely in the schools. This metamorphosis has taken psychotherapy out of the hands of the psychiatrists and psychologists and placed it in the hands of teachers and school guidance counselors. This devolution of power suggests that cultural therapy may help reduce mental health stigma and be an agent of liberation psychology in oppressed and impoverished communities.

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Brain Gain in Uganda: A Case Study of Peer Working as an Adjunct to Statutory Mental Health Care in a Low-Income Country

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The Rationale for Involving Peer Support Workers in Mental Health

People with mental health problems are more likely to experience violence, abuse, stigma and discrimination, restricted political and civil rights, reduced participation in society as well as a lack of access to health, education and employment (Funk et al. 2010). In all resource settings, people living with mental illness are at risk of remaining in and drifting towards poverty, in a negative cycle (Lund et al. 2011). These challenges have been described in Uganda, in a context of high psychosocial burden for the population plus reduced opportunities and discrimination against people with mental illness (Ndyanabangi et al. 2004).

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Uganda, with a population of 37.5 million and one of the highest birth rates in the world, is considered a low-income country: an estimated 24.5% live under the poverty line (World Bank 2014). Over two million people live in the rapidly expanding capital, Kampala. Epidemiological studies have found high rates of mental health problems, with 21–24% suffering from depression (Bolton et al. 2004) and 30.3% suffering from mental illness generally. There are 25 psychiatrists in Uganda, 7 of whom are based at Butabika Hospital, the 450-bedded national referral and teaching hospital located on the edge of Lake Victoria on the eastern outskirts of the capital, Kampala. This was built in 1954 as a 970-bedded asylum, to replace former more custodial asylums at Hoima (1920) and Old Mulago (1930). Butabika took referrals from all over the country until a policy of decentralization in the late 1990s led to the strengthening of regional mental health services, with Mental Health Units being built in 12 major towns in 2004. These are run mainly by Psychiatric Clinical Officers, although three have a psychiatrist.

A number of different studies have described indigenous classifications of mental illness (Orley 1970; Ovuga et al. 1999; Abbo 2011; Okello 2006). Explanatory models for mental health problems cite clan issues, including ancestral spirits and witchcraft, as well as physical illness and substance misuse (Abbo 2011). These attributions may contribute to discrimination and also to families feeling shame and hiding family members with mental illness (Ndyanabangi et al. 2004), both of which reduce educational or vocational development (Ndyanabangi et al. 2004; *BasicNeeds* 2007).

National Health Service (NHS) International links are partnerships between health institutions in the UK and counterpart health institutions in LMICs. There has been a long history of overseas volunteering by UK-based health professionals, and over the past 25 years, the Tropical Health and Education Trust (THET) has supported and built a partnership approach that aims to harness knowledge and technical expertise to strengthen health systems through the training of healthcare workers in low-income settings (THET 2014a). This approach has been endorsed as a method of supporting development of overseas partners, and potential benefits to UK institutions have been highlighted, particularly improved skill and knowledge to serve diverse communities (Crisp 2007). UK Department of Health guidance advocates that links should embrace a principle of mutual benefit and ensure primacy for and ownership by the low-income countries being partnered (Crisp 2007). BELL, formalized in 2005, is a partnership between Butabika Hospital and East London NHS Foundation Trust (ELFT), a large London-based NHS Trust[1] providing mental health services to some of England's most diverse and impoverished populations.

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[1] 'Trusts' in the UK context are divisions of the National Health Service that provide health care to a specified geographical area or in a particular medical speciality.

Mental Health and the Recovery Agenda

The 'Recovery Approach' (see chapter by Aldersey, Adeponle, & Whitley in this volume) describes a broader framework for understanding people's efforts to adapt to experiences of mental illness, rather than simply an overarching description of symptomatic relief. Recovery defies easy definition due to the personal nature of the recovery journey. One definition describes Recovery as:

> a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful and contributing life, even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness. (Anthony 1993, p. 17)

Professionals identify hope, agency and opportunity as key characteristics of a 'Recovery Approach' (SLAM/SWLSGT 2010) whilst service users also highlight spirituality, empowerment, connection, purpose, self-identity, symptom management and combating stigma (Slade 2010). In the limited research on recovery in minority populations living in high-income countries, the importance of spirituality, religion and the role of traditional healing, experiences of personal and institutional stigma and discrimination, and the impact of collectivist values have been highlighted (Leamy et al. 2011, Todd et al. 2012; Kartalova-O'Doherty and Tedstone Doherty 2010).

Whilst it was unclear how the 'Recovery Approach' might translate to a Ugandan setting, descriptions of mental wellbeing in Uganda have a holistic underpinning:

> a state of physical, spiritual, social and financial health enabling participation in daily activities and contribution to the well-being of others. (Ndyanabangi et al. 2004, p. 55)

Despite this, Ugandan mental health services favour approaches that emphasize biomedical models of care (Abbo 2011). Although biomedical approaches similarly remain dominant in the UK, the NHS espouses a commitment to the 'Recovery Approach' and service user involvement, as reflected in national policy documents such as *The Journey to Recovery—The Government's vision for mental health care* (DoH 2001) and *Creating a Patient-Led NHS* (DoH 2005). The BELL acknowledges that its work should be tailored to the social and cultural context of the user and that carers and users are key partners in service development (BELL 2014).

Throughout the life of the BELL, there have been independent efforts by Ugandan-led organizations advocating for the voice of local service users. Mental Health Uganda focuses strongly on disability rights and local empowerment (MHU 2014), BasicNeeds provides advocacy skills and opportunities to grow sustainable livelihoods (*Basic Needs* 2007) and the Pan African Network of People with Psychosocial Disabilities (formerly the Pan African Network of Users and Survivors of Psychiatry) advocates for a greater recognition of the potential and expertise of people who have experienced mental health problems (PANUSP 2014). Each one of these user organizations, whilst not formal collaborators on the project, has a representative on the Board of Heartsounds Uganda (HSU), the user group that provided user leadership within this case study.

The Case for Peer Support

With expertise located with those who embark on the journey of recovery, peer support development is a natural extension of the 'Recovery Approach'. Peer support has been defined as 'social, emotional and practical support offered, by people who have experience of a mental health condition, to others with similar mental health experiences in order to work mutually to bring about desired change' (Repper and Watson 2012, p. 70). Peer support can be delivered in a variety of ways including within mutual support groups, as peer support services or as peer mental health service providers (Lloyd-Evans et al. 2014). A distinction has also been made between informal and formal peer support (Repper and Carter 2010), with formal peer working including peer support offered within peer-led programmes and PSWs employed within statutory services.

An experiential learning process, the mutual nature of peer support (i.e., that PSWs both give and receive support) and the importance of peers remaining in control of these services have all been described as essential ingredients of peer support services (Mead et al. 2001; Solomon 2004). Working for the recovery of another person facilitates recovery in the PSW (Clay 2005), and engaging in a form of listening in which meaning from stories is sought assists recipients to reconstruct their identity beyond stereotypes and the perceptions of the dominant biomedical framework (Mead et al. 2001). The form of training, described later, fosters this form of listening and storytelling.

Research has examined the overall effectiveness of peer support to reduce admission rates, prolong community tenure and enhance wellbeing. A recent review of randomized controlled trials (RCTs) of peer working in statutory services in high-income settings comparing care with and without peer working showed that peer support 'results in psychosocial, mental health symptom and service use outcomes for clients that were no better or worse than those achieved by professionals employed in similar roles, particularly for case management services' (Pitt et al. 2013, p. 23). However, there have only been a few RCTs of peer support and these studies have evaluated different models and have used varying outcome measures and have different sources of bias: this makes it difficult to draw conclusions based on aggregating these trials. Lloyd-Evans et al. (2014) point out in another systematic review that there has been a bias in the research conducted to date in that it has focused on determining whether peer support is *better* than standard care (and has generally shown that there is no difference). There has thus been inadequate focus given in research designs to date to test whether peer support is perhaps *worse* than standard care. More recently Simpson et al. (2014), in a UK study, showed both cost effectiveness and some indication that peer workers based in statutory services reduced feelings of hopelessness.

Research focused on recipients of peer support has suggested PSW can foster more stable mental health (Ochoka et al. 2006), empowerment (Resnick and Rosenheck 2008; Corrigan 2006; Dumont and Jones 2002), the sharing of practical strategies for recovery (Campbell and Leaver 2003), as well as improved social and work functioning (Yanos et al. 2001; Ochoka et al. 2006). Other benefits include recipients feeling listened to and understood (Davidson et al. 1999; Sells et al. 2006; Campbell and Leaver 2003), gaining a more hopeful stance (Campbell and Leaver 2003), a care experience marked by PSWs providing quality attention rather than being unhelpfully focused on tasks (Paulson et al. 1999), and gaining new approaches to challenge stigma (Ochoka et al. 2006). In a LMIC setting, recent results from a peer support project in Gaza pointed to increased perceptions of hope, self-confidence and community inclusion by peer workers (Weissbecker 2014).

Research shows that the benefits to PSWs include increased spiritual and mental health (Moran et al. 2012; Bracke et al. 2008), greater hope and self-esteem (Ratzlaff et al. 2006), improved life skills and confidence (Salzar and Shear 2002), a greater sense of empowerment (Moran et al. 2012; Bracke et al. 2008; Resnick and Rosenheck 2008; Dumont and Jones 2002; Corrigan 2006), financial rewards (Mowbray et al. 1998), increased skills contributing towards employment and independence (Moran et al. 2012; Mowbray et al. 1998; Ratzlaff et al. 2006) and new opportunities to challenge discrimination (Mowbray et al. 1998; Ochoka et al. 2006).

In terms of institutional benefits, it has been suggested peer workers can assist navigation of health systems by acting in a bridging role (Chinman et al. 2006), challenge institutional stigma (Davidson et al. 1999) and promote better staff attitudes towards people with mental health problems whilst sharing tasks (Dixon et al. 1997). PSWs, simply by their presence and engagement within statutory teams, offer an opportunity to forge a new form of relationship less defined by traditional roles. Therefore, the employment of PSWs offers both a quantitative increase in workers and a qualitative change in relationships and the way work is delivered.

Peer working also presents challenges. It necessitates a re-evaluation of boundary issues around disclosure and sharing of information, can emphasize power differentials, lead to stress in PSWs that requires well-thought-out responses and raise issues of accountability related to risk and of identity within a dominant system (Repper and Carter 2010). This suggests a need for adequate training, supervision and support to combat stress (Woodhouse and Vincent 2006).

Certain key topics have been identified for training including: the Recovery Approach, the nature and scope of peer support and listening skills (Repper and Carter 2010). Woodhouse and Vincent (2006) noted varying length of training and differing formats within peer work programmes and the balance to be struck between preparation of PSWs and ensuring they have the freedom to operationalize their lived expertise. The authors also noted that health professionals needed training to ensure commitment and support for peer activity.

Bringing the Project to Life

In 2008, the BELL created *Heartsounds:* a two-week multimedia learning journey aimed at making service users' involvement central to the collaboration's work. This involved service users and service user champions from the UK meeting their counterparts in Uganda to share knowledge and inspiration to bring attention and credibility to the Ugandan mental health service user voice (HSU 2014).

The initiative resulted in Butabika Hospital's first user-led conference, connecting interested health professionals with talented service users; a web platform for ongoing sharing between Ugandan and UK users and health professionals; a recognition at the highest level of the Ugandan government that user involvement was desirable; and most importantly, a recognition that Ugandan service users had expertise, energy and skills to support the development of mental health services; and suggested a number of priorities including increased user involvement, the need for community-based care, and opportunities to work and combat stigma and social isolation (Heartsounds Conference 2008).

The *Heartsounds* initiative led to the development of *Heartsounds Uganda* (HSU), a Ugandan-inspired service user group run and managed by people with a lived experience of mental illness. Joseph Atukunda, a logistics professional who had forged his own recovery from bipolar disorder, was inspired to create a user-led and user-run organization that recognized and promoted the expertise of people with a lived experience of mental illness.

In 2010, one of the authors (CH) was involved in a trial of peer working for clients being discharged from ELFT inpatient wards (Simpson et al. 2014) which led to increased online discussion between HSU and UK colleagues on peer working. HSU was already offering support to peers. Additionally, there was recognition amongst partners that peer support represented a form of mental health care provision that could shift tasks away from the few mental health professionals available in Uganda.

In 2011, BELL, in collaboration with HSU, obtained funding to pilot peer working in primary care in Kampala and surrounding districts. These PSWs would be described as formal by the fact they provided care as an adjunct to the eight-person Community Recovery Team (CRT), comprising four psychiatric nurses, with input from two social workers, a psychologist, an occupational therapist and psychiatrists that serve that area. However, they also provided informal support in addition to standard care. HSU operated as a stand-alone peer support organization, offering a range of other 'peer spaces' that provided creative opportunities, access to loans and credit, employment training and social connection through a café, a film club and a Hearing Voices Group.

The training and project development process was inclusive of all stakeholders from the outset with the role, function and administration of the PSWs co-created between 6 members of the Community Recovery Team of the Hospital, 12 core members of HSU and facilitators from the BELL. The training was carried out over two cohorts with a total of 26 peer support workers eventually working within the initiative. Primacy was given to ensuring that the collaborative activity and PSW training were congruent with a living example of mutuality, reciprocity, empathy and the recognition of the expertise of the lived experience. This was done through emphasizing and highlighting learning and expertise, using methods that drew out commonalities, interdependence and aspirations (Box 30.1).

Box 30.1 Examples of how project values were demonstrated

Peer support work projects in non-mental health settings were visited by a staff member and service user who carried out and reported on the task together.

Opportunities for reflection and learning for the group at the beginning and end of each day were standard and shaped the format and style of the training.

The majority of the questions generated by the training were directed from the trainers back to participants to highlight their expertise by experience.

A patient from the hospital who wandered into the training was accepted by the trainers as an active participant and ate with the group.

The Leadership Group

The first cohort was a development group made up of User Leaders (ULs). The goal of the initial training was to facilitate this extraordinary group to lead the development of the *Brain Gain* project. In the absence of other mental health peer support programmes in Uganda, ULs visited HIV- and substance-abuse-related peer programmes. They also co-produced the peer-working model clarifying their role, catchment, operational method, key activities, protocols, guidelines on conduct, support structures, financial arrangements and reporting tools.

The first training, in May 2012, involved 12 members of HSU, 6 members of the CRT and facilitators from the BELL. They undertook a process of pre-training collaboration, actual training on illustrating and celebrating lived experiences of recovery and peer expertise, feedback post training, piloted peer work activity and further feedback to ensure relevance of future training. This extensive leadership of service users in the development phase enhanced the sense of agency and modelled collaborative working with professionals. Participants in the first cohort were initially introduced to recovery-related language and underpinning ideas: however, it was found relatively quickly that importing concepts of recovery worked against a stance of uncovering Ugandan expertise, and therefore it was jettisoned for more experiential discussion and modelling of an enquiring stance. The trainer noted a decrease in attention and interest in the training room when presenting recovery material previously utilized in the UK. The trainer quickly changed tack to one of asking questions and exploring broad themes about personal experiences of recovery and hopes for peer working, an approach that continued throughout the training.

The training focused on ability and expertise rather than upon pathology, symptoms and weakness. The training style and content was informed by participant choice. The narrative therapy-inspired *Tree of Life* (Ncube 2006), in which the metaphor of a tree is used to draw out the presence and history of strengths, values and hopes, was utilized, as were comparisons with other forms of stories had been told about people's experience. Learning opportunities were facilitated within a 'wellness plan', which collated key information about what supports and undermines recovery and highlighted goals for each participant. Another important exercise was the 'Super Hero Exercise' in which small groups developed Super PSWs with idealized skills, resources and qualities. This helped participants explore their hopes and also provided an opportunity to investigate potential challenges and realistic reflections about their ambitions as PSWs. Examples of Ugandan qualities included long legs and special sandals for persevering with long walks into communities to bring hope against stigma to people living there. The training focused on the group developing a sense of seeing each person as unique and moving away from an advice-giving role to listening and empathizing with the other person's point of view. This was done in a variety of ways including modelling this stance, training participants in key communication skills (including questioning and summarizing skills), and using whole room scaling exercises to identify a range of views on contentious issues and providing opportunities to speak respectfully across this range of viewpoints.

All user participants were also offered Management of Actual and Potential Aggression (MAPA) training by hospital-based trainers. With its emphasis on recognizing early signs of aggression and preventing violence through positive communication, these sessions responded to specific concerns of the pilot group about visiting hospital wards and people's homes.

CRT members shared their lived experience of mental distress and well-being with incredible openness. At the culmination of the training, all participants (CRT included) received certificates and red peer-working t-shirts (emblazoned with their role title and the name of partners in the project plus the words 'Lean on me' in script) and were inducted as official volunteers of the hospital. This initial group piloted peer working and attended to early logistical and political challenges.

The second cohort was trained five months later. This training differed from the first in that the role had been defined, tested and feedback from existing PSWs obtained as to training needs. Many of the exercises were similar with added testimonials and perspectives provided by existing PSWs.

Once trained, PSWs attended fortnightly 'Mutual Support Groups' (MSGs) where they could reflect, in a safe and supportive environment, on meeting the challenge of peer working. Long-term volunteers assisted the facilitation of the group by promoting a cycle of continual reflection and exploration of peer expertise. Further support was provided through PSWs receiving some supervised support from professional staff as well as informal contact between peers. Communication opportunities between participating staff and service users were enhanced by providing free mobile phone calls between members.

Preliminary Evaluation of Brain Gain

Given the fact that a new model was being co-created, the evaluation necessarily took in a variety of qualitative and quantitative measures and, in keeping with the principle of use involvement, PSWs were heavily involved. Early evaluation data revealed the training programme was effective in readying participants to become PSWs. The 'Recovery Star', a 10 point Likert scale tool measuring in 10 life domains (managing mental health, living skills, social networks, work, relationships, addictive behaviour, responsibilities, identity and self-esteem and trust and hope) (Donnelly et al. 2011) was then utilized. Although primarily a tool to promote individual planning, data can be aggregated as a means of monitoring changes in a population over time.

Completion of a Recovery Star showed definite improvements were felt for PSWs in areas related to identity, self-esteem, physical health and self-care, plus some indication that social networks, trust and hope were positively affected (Baillie et al. 2013). PSWs increasingly agreed that environmental factors can contribute to patient aggression and violence and that alternatives to the use of containment and sedation to manage patient violence could be used more frequently.

Six semi-structured interviews of recipients of peer support work were carried out by an independent evaluator to understand the impact of PSW (Baillie et al. 2013). This pointed to an increased sense of hope, inspiration and encouragement, combined with distinct learning about their mental health conditions. There were also positive changes to family relationships and experiences of stigma (Box 30.2). The following quote from Grace, a 37-year-old recipient of peer support provides an example of the perceived benefits that PSW offered:

Box 30.2 PSW care in action

Godfrey is a 35-year-old man living with his parents in Luzira. With experiences of psychosis and alcohol abuse, he has had 16 admissions to Butabika Hospital since 1998. He was referred from Biina Ward and met his PSW for the first time at the Hospital PSW office.

The PSW noticed that Godfrey struggled with his alcohol cravings and felt a lot of anxiety and loneliness. He also had difficulties with his family who had stripped him naked to stop him leaving the house to drink or when his behaviour was difficult. The PSW talked about Godfrey's hope to work again and gave reassurance and listening time. This living example of recovery reassured and inspired Godfrey and his family. Within whole family discussions the PSW shared salient elements of her experience.

The PSW then met Godfrey at home on numerous occasions. At times, family members were also present, and the PSW facilitated discussion with them about how they could best support Godfrey moving forward. Godfrey was thankful for the help and saw the PSW as a role model for what is possible. Godfrey's father was invited to the Hospital Carers group. Godfrey relapsed several months after leaving hospital, but the peer worker maintained contact through meetings and assisted him to avoid a hospital admission through encouraging him to reduce his alcohol use and set some basic recovery goals. Godfrey's family members were happy with this support and also agreed to see the psychologist as a group to consider how this could help Godfrey. The PSW also introduced Godfrey to a peer worker with experience of alcohol addiction.

**Names and some details changed here and in the rest of the chapter to ensure anonymity*

> They have given me support, as in emotionally and socially, one of it is that they give me courage, they come around and they talk to me about hope, about what is really good, what I can attain.

Focus groups of PSWs at the end of the project indicated increased confidence and self-worth, much mutual learning and personal development (Baillie et al. 2013). PSWs felt a sense of belonging, pride in their success and ability to offer hope, and a newly empowered stance on stigma and gaining future work opportunities. The following quote provides an example of how PSWs appraised their experience. Paul, a 45-year-old peer worker said:

> My family see me as a success story. Work in a hospital, can contribute to my family; they see hope in me, in my dealings with them and with my future. I'm not the man who stays in bed while my wife is doing everything.

In relation to the challenges experienced by PSWs, focus groups (Butabika East London Link 2013a) revealed how building initial engagement and trust with peers was at times difficult, as was operating within the limited financial facilitation provided by the project. Furthermore, PSWs' personal experiences of poverty made refusing peer requests for resources more challenging.

Whilst working with families provided opportunities for constructive progress, it could also lead to tension and frustration when families discouraged PSWs or behaved in unhelpful or even abusive ways. As such, the PSW's role provided not only practical difficulties but also psychological challenges related to the responsibilities and expectations it held. Josephine said:

> Linking up with peers, meeting up with new peers is very challenging. They don't understand what you're talking about or what you want. It's hard to engage them so they trust and believe you. Eventually you can overcome this.

Staff also highlighted the issue of how the incorporation of the PSW cadre raised potential problems of accountability, consistency and quality of health message and behaviour. There was a shared belief that a greater degree of supervision and support was necessary to assure the work of the PSWs. Staff focus groups described an institutional increase in optimism, a decrease in stigma in the hospital, improved communication between users and professionals, positive teamwork and equality between PSWs and the team most involved in the programme (Butabika East London Link 2013b).

Prossey, 34, who worked as a PSW said:

> Before, the patients would leave and hide in the community so they (professionals) would never see the end result. But now they see recovery and this makes them happy. It's amazing their attitudes have changed.

Reflections on the Strengths and Weaknesses of the Project

The pilot project demonstrated that formal peer working within existing statutory services in Uganda is possible, but further exploration is required to establish whether this would be applicable to other low-income settings. This pilot suggests that peer working may offer promise for both improving the dire human resource situation and reducing exclusion and discrimination of users.

Before embarking on this ambitious programme, the partners of this project benefited from several years of shared work. The programme inception, development, structure and delivery modelled reflectivity and reciprocity and a recognition of the mutual benefit of the experience for all stakeholders.

On a broader level, this has enhanced the relationship between the partners of BELL by helping the UK members avoid, either through a lack of awareness or arrogance, the tendency to unintentionally dominate the development agenda. UK members witnessed Ugandan colleagues skilfully maintain their commitment to the peer-working programme despite facing many challenges, including institutional hostility and individual conflict. The commitment to the primacy of the user voice by both the UK and Ugandan teams created the space where Ugandan colleagues (both in country and within the diaspora) could bring their expertise and perspective to bear.

Pare (2013) noted that user participation has undergone typological changes since the 1940s when ‘public co-operation’ was used, before being superseded by ‘people’s participation’, ‘community involvement’ and ‘user empowerment’ in turn. She describes ‘user empowerment’ as participation through leadership of services, research and all project management elements. Although the NHS collaboration between service users and staff in developing care and services is considered good practice (DoH 2005), often the role of key citizens to create social innovation is cordoned off into the implementation phase only (Voorberg et al. 2013). Unlike the NHS, which has specific processes created to promote user involvement, this project development was of such novelty for Uganda’s statutory mental health services that it created completely new processes for collaboration. We believe that this created a user leadership experience of the highest order.

The dominance, in numbers, of service users within the development of this project, promoted ownership and leadership. The courage of Ugandan health managers and workers to collaborate in this context plus the nature of HSU as a user-led and user-run organization were key factors in making full use of that opportunity. The overall project focused on co-creation within all aspects of the project. This created a dynamic and self-sustaining vehicle that not only delivered a service but also educated all involved about recovery and mental health.

HSU initially took form around the inspired commitment of an individual service user leader who saw the potential of their voice being heard. People who entered the peer support scheme entered into these larger opportunities meaning that the formal peer work programme was built on a foundation of a wider informal peer support network. This larger pool of service users also provided a source for new PSWs.

The increased leadership capacity of HSU and the learning gained through the peer-working project are demonstrated by their successful bidding for three further grants since the pilot ended. HSU represented and drew in service user leaders from the outset who took the opportunity to run what was a complex and challenging programme. Initially, staff members were sceptical about the capacity of service users to administer the programme, particularly the finances; however, by the end of the pilot project, there was widespread agreement that the project had been run to a high standard.

Part of the role of the UK partners was the creation of a positive risk-taking space within which service users could gain skills and experience to lead. UK partners held an optimistic and hopeful stance about service user capacity that translated into new opportunities for action.

Recovery and Uganda

It is important to reflect on the cross-cultural relevance and appropriateness of the 'Recovery Approach'. The development of the *Brain Gain* project necessitated an exploration of the recovery perspectives of Ugandan service users. These generated areas of expertise and interest that certainly resonate with recovery principles in high-income countries. With current perceptions of recovery grown from the voice of individuals talking about their experiences of mental ill-health (Slade et al. 2008), and those individuals mostly coming from high-income countries, the apparent lack of opportunities for Ugandan service users to share their accounts may mean that the process of defining a Ugandan concept of recovery has only just begun.

One of the areas where the Recovery Approach appeared to pose some challenges in Uganda related to the emphasis that it places on individualistic notions of progress and wellbeing. Ugandan culture, whilst represented by great diversity of approach, generally has a much more collective understanding of the cause and the treatment of mental distress. This understanding of recovery resulted in several unique initiatives. The development group created a peer-working role specifically for caregivers. This role worked in concert with PSWs' visits and involved liaison with families about recovery. These caregivers then established a caregiver support group at Butabika Hospital and several other PSWs started similar groups in their local neighbourhoods.

Any exploration of recovery within a Ugandan context needs to take into account the lack of a government-created safety net for people who become unwell. The impact of poverty, violence, stigma and limited opportunities for individuals with a lived experience of mental health difficulties in Uganda cannot be underestimated. On one hand, this may give rise to a hunger for change and inspire opportunities for entrepreneurialism, yet on the other it may mean that individuals reject treatment altogether on the basis of the adverse social implications of receiving treatment and additional drawbacks of the treatment itself, for example, custodial care in overcrowded wards, medication with high side effect profiles and so on. Therefore, it is essential that continued exploration of the 'Recovery Approach' in Uganda happens with a good understanding of the social and economic consequences of becoming unwell. It is hoped that further development of understanding about the Recovery Approach from a Ugandan perspective will be transferable and has validity elsewhere, including for the Ugandan diaspora in the UK.

Training and Development Processes

Having staff and service users learning and working together towards a shared goal had a powerful impact. The goal was not 'user involvement' per se: the goal was instead the development of a new way of construing, constructing and delivering services. In choosing potential PSWs, the pool of suitable service users with a year or more of wellness was small. Therefore, we relied on word of mouth and personal assurances from peer leaders and potential workers of readiness rather than a rigid selection process. The first group of PSWs also enlisted some of the next group from the people they had visited. Therefore, it may be that in a LMIC setting, the choice making for suitable peers for formal work will be a different and perhaps more opportunistic process that is less attached to a criterion of 'stability'.

The training model appears to have had a transformational effect on staff and service user participants and may be a useful stand-alone educational intervention. It may be that this type of programme within low-income settings can help to generate a critical mass of service user leaders and identify the expertise to enhance existing efforts on mental health. The training, followed by the working partnership between staff and service users, appears to have also been an important factor in promoting attitudinal change: it may be that this type of training could be delivered more widely with outcomes of activity sufficiently open to allow new innovation and culturally derived versions of peer support to arise.

Challenges and Limitations

In conducting the pilot project, fairly distributing finances to support PSWs proved to be a challenge. Initially, a monthly stipend was paid to PSWs. However, when it then became apparent that not all peer workers were carrying out equal amounts of visiting, a ‘payment by results’ amount was initiated in consultation with service users. Throughout the programme, the larger issue of whether a living wage is a feasible aspiration in an underfunded and overburdened mental health system was not fully resolved. A lack of adequate remuneration was an ongoing stressor for PSWs, who were often struggling with minimal opportunities in the job market. Aspiring for a living wage for PSW therefore seems an ideal aspiration for bringing positive change to service users.

Working as PSWs was at times stressful, especially offering a service and developing relationships with service users at their homes. Also, as PSWs became more visible, they were soon being asked by ward staff to complete other tasks. Whilst the project leads recognized the need for peer working to develop organically, there was a simultaneous acknowledgement that they also need some ‘protection’ from being swallowed up by an overburdened institutional setting.

At different points, PSWs and hospital managers expressed concern about the expectations being placed upon PSWs. Whilst wellness plans had been created during the training, they were not well used when stress was identified. The mutual support groups served an important function in that they identified when people were struggling or even absent and gave an opportunity for peer support to be delivered within the group. The mutual support groups also provided ongoing testimonials of recovery.

Some staff were very opposed, and even hostile, to the PSW initiative. An explicit decision was made to focus initial efforts on working constructively with staff that were supportive, or at least neutral towards the scheme, rather than engaging in ongoing battles to win over entrenched opposition.

A limitation of the pilot was the inability to incorporate the planned ‘train the trainer’ component within the training. Within the tight deadlines of the pilot project, it was soon apparent that the project group was not yet ready to take on this training. Whilst the second training created opportunities for existing PSWs to give personal testimony, further work is needed to ensure service users have the skills and confidence to lead and facilitate future training.

This was not a research project but a collaborative development initiative to see if peer support was feasible and acceptable. Partly due to limited resources to undertake evaluation and partly due to the intention to involve PSWs in all aspects of the initiative, including evaluation, all PSWs were involved in data gathering and evaluation. There was limited opportunity for quality control and so the data was of an uncertain quality. We would recommend external evaluation of the project or a means of assessing the strength and consistency of internal evaluation.

In future, it would be worth understanding the drive and benefits of being prescriptive with health information in Uganda. The dissemination of 'instructions' to individuals and groups is a common mode of operation for health professionals. This may be driven by a concern that if key information is not transmitted with sufficient urgency, a person is more likely to experience the devastating impact of getting unwell in an extremely harsh setting.

Recommendations for Future Work and Conclusions

- Create a safe and empowering training and development context

The training method focused on creating a safe space for hearing the expertise of professionals and service users across cultural and professional/user boundaries. Potential power imbalances were identified and attended to through choice making, weight of numbers, and gender balance of participants and facilitators. This appears to have enhanced the sense of safety that staff and service users felt.

- Commit to key principles and exploration of cultural fit

There is a tension between the need to scientifically measure the benefit and activity of such peer-working initiatives and the need to maintain the dynamism and freedom of movement of such a project. Perhaps the middle path relates to the commitment to key principles and ways of working. Key principles of this project included partnership working; valuing people 'in the room'; exploring ideas rather than imposing; nurturing culturally valid understandings and activities rather than predetermining what form an intervention will take; redressing power imbalances; explicitly and truly sharing ownership; modelling positive relationships across cultural, gender-based, vocational and social divides; and encouraging creativity.

- Engage in positive risk taking in the service of co-production

Staff and service users developed the PSW model together, and solved problems as they arose. Ugandan managers, by their willingness to accept risk within the project, championed the hope and importance of positive risk taking, an element noticeably less visible in the UK. Also, the project, having not applied a strict selection process on Ugandan participants, worked successfully with a group of Ugandan service users at different stages of wellness and recovery. These service users delivered all elements of a complex programme, which illustrated the capacity of people to rise to the challenge when opportunities are provided. Perhaps it points to a general tendency within UK services, to overprotect service users and underestimate their capability to take up new opportunities.

- Nurture long-term partnerships with supporters

It is difficult to assess the importance of UK partners' contribution towards the project as it covered over eight years and involved many individuals and roles. The UK partners facilitated a learning space, promoted exploration, modelled mutual learning and built capacity of others by supporting and working alongside. This was enhanced by the presence of long-term volunteers who acted to reassure stakeholders' anxieties, build confidence in the process and promote the 'safe spaces' of the training to stay open and accessible to all. This contribution was less focused on the training in technical expertise typical of international work and more about creating a respectful process of change.

Conclusions

This peer-support-working pilot project has offered powerful experiences of individual and group triumphs over stigma, alienation and isolation. *Ascari*s (guards), who had previously acted as custodians of service users on the wards, now delivered aggression management training to their service user colleagues. CRT workers visited the ward to see their female friend and colleague PSW and then responded to her complaints about care in an assertive and meaningful manner. These stories demonstrate the opportunity for inspiration and hope that peer support working can offer.

Within high-income settings, the indications are hopeful that peer support working can provide a range of potential benefits to PSWs, recipients and institutions. If some of these benefits are transferable to a low-income setting, the exponential impact is exciting to consider. With the power of individuals living with mental health problems in poorer countries weakened in many institutional and community domains, the employment of PSWs within statutory services may represent a penetrative step change in mental health care. There are stark differences in low-income settings such as a lack of human resources (Kakuma et al. 2011) and overt and wide ranging stigma and misinformation (*BasicNeeds* 2008) that may mean the formal utilization of PSWs may have an impact that far exceeds that felt in the relative privilege and welfare protection of wealthy countries.

There is currently a lack of evidence related to peer support services being provided within statutory mental health service providers in LMICs. With this in mind, there is a need to move towards more formal testing of feasibility and effectiveness in such a setting. There is however a danger that in the haste to formalize peer work for 'testing' purposes, the voice and power of service users within the design and delivery of such services will be sidelined. If formal testing is to promote innovation and a broad range of positive outcomes, it must be based upon the full participation and support of user leaders and a foundation of transparent, flexible collaboration.

Peer working offers an area of Global Mental Health development that can pay more than lip service to the expertise of people with lived experience and in doing so, tread a path away from simplistic understandings of mental health problems in LMICs and towards a culturally sensitive approach that builds on existing social capital and strengths. The Heartsounds Uganda example has begun to demonstrate the broad benefits that may be generated through the ethical application of a peer-working programme.

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31

commit and act in Sierra Leone

Corinna Stewart, Beate Ebert, and Hannah Bockarie

Sierra Leone: Current Issues and the Legacy of the Civil War

Sierra Leone is located in West Africa and has a population of six million composed of approximately 16 different ethnic groups. While English is the official language of the country, the most widely spoken language is Krio (although other languages such as Mende and Temne are spoken within different regions). It is one of the poorest countries in the world, ranking 183rd out of 187 countries in the Human Development Index (United Nations Development Programme 2014). The life expectancy is 45 years for men and 46 for women (WHO 2012). Health expenditure is low. In 2012, the sum of public and private health expenditure per capita in Sierra Leone was 95.7 US dollars (17.5% public expenditure) compared to 8895.1 (47% public) in the United States and 3647.5 (84% public) in the UK (World Bank 2015). Neuropsychiatric disorders are estimated to contribute to 4.1% of the global burden of disease in Sierra Leone; however,

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there is very limited data on the current prevalence rates of mental health issues in the country (WHO 2011). It is estimated that less than 1% of people with mental health difficulties are treated within psychiatric services and the rate of relapse is high (Sierra Leone Ministry of Health and Sanitation 2012).

Sierra Leone has also endured a turbulent recent history. The country was devastated by a civil war between 1991 and 2002, in which 40,000–50,000 people were killed and 500,000 civilians fled the country (Dufka 1999). The war was characterized by brutal atrocities against civilians, including widespread execution, amputation of limbs, and rape (UN Development Programme 2006). The mental health of the population has been affected greatly by the civil war. Findings from an assessment of traumatic stress in the capital, Freetown, toward the end of the civil war by Médecins Sans Frontières (MSF) indicated that 99% of respondents demonstrated very high levels of disturbances on the Impact of Events Scale, which assesses two central dimensions of coping with extreme life events: intrusion and avoidance (de Jong et al. 2000). During the war, approximately 22,000 children were abducted, forced to watch and carry out violent acts and suffered physical and sexual abuse (Denov 2010). Sexual violence was also used a weapon of war during the conflict. Physicians for Human Rights (2002) reported that internally displaced girls and women within Sierra Leone were subjected to an extraordinary level of rape, sexual violence and other human rights violations. Of the women and girls who participated in their survey, over half of those who came into contact with the Revolutionary United Front reported sexual assault. Longitudinal research has indicated that individuals who wounded or killed others during the war demonstrated increases in hostility and that youth who survived rape exhibited higher levels of anxiety and hostility across time (Betancourt et al. 2010). MSF concluded that the high levels of traumatic stress observed indicate an urgent need for psychosocial interventions to address the needs of the survivors of violence and that Sierra Leoneans must be involved in the development and delivery of these interventions (de Jong et al. 2000).

In addition to war-related trauma, the country has also been faced with a number of other issues, including poverty, unemployment, stigma (e.g., child soldiers, victims of sexual violence, mental illness etc.), domestic- and gender-based violence, as well as poor infrastructure and a lack of resources. Gender-based violence continues to be a widespread problem across the country and evidence suggests that domestic violence against women and children is common (Denney and Ibrahim 2012). For instance, Coker and Richeter (1998) found that approximately 70% of urban women interviewed for a survey on AIDS revealed that they had been beaten by an intimate male partner and over 50% reported being forced to have sexual intercourse. Current prevalence rates of domestic violence and rape are difficult to clarify as these crimes are greatly underreported, police are reluctant to intervene in domestic disputes, and complaints are often withdrawn due to social stigma, fear of retaliation or acceptance of payment in lieu of pressing charges (U.S. Department of State 2013a). More recently, the Ebola Virus Disease (EVD) epidemic has had a devastating impact on the already vulnerable and unstable country. Sierra Leone was among the worst affected countries, with 12,371 suspected, probable, and confirmed cases and 3899 deaths due to EVD reported by April 2015 (Centers for Disease Control and Prevention 2015). This has been attributed in part to the inadequacy of the health care systems in the country.

There is also a serious lack of mental health services and community care, and the few available services are limited in scope and trained personnel (Song et al. 2013). The country has only one psychiatric hospital, which is grossly understaffed and under-resourced, as evidenced by the fact that there are only two trained psychiatric nurses tasked with the responsibility of managing the 400-bed hospital. There is also only one psychiatrist in the country, and he is retired from active government service. Following a recent situational analysis, the Ministry of Health and Sanitation (2012) has outlined the shortcomings of the current mental health system, proposed strategies for its improvement and identified key groups that require particular attention in future design, planning and implementation of mental health services. Within this report, the Ministry has recognized the need to shift the emphasis of treatment to community-based psychosocial programs to improve access to mental health care, reduce the stigma associated with attending mental health services, lessen burden on individuals, families and communities, and ensure smoother social integration and better chances of recovery. Recent efforts have been made to foster collaboration between different sectors, including beyond the health sector (e.g., traditional healers, religious leaders), and to promote research to monitor, evaluate and inform services and to ensure that they are evidence-based.

commit and act

commit and act is a German-based NGO that provides training and continuing supervision in Acceptance and Commitment Therapy (Hayes et al. 1999) in low-income countries (LICs) and has a local partner in Sierra Leone

(White and Ebert 2014). *commit and act* works with a variety of different professions (e.g., social workers, teachers, religious leaders, prison officers etc.), as well as non-specialized workers, NGO staff and established local groups (e.g., women's groups). Their international team includes psychotherapists and other mental health practitioners, ACT trainers, researchers and individuals with various skill sets (e.g., finance etc.), linked by a shared vision of connecting with others, caring for others' well-being and personal growth, and creating contexts that empower people to realize their own vision, goals and ambitions, as reflected by their motto: 'connecting, caring, creating'.

The Functional Contextual Approach: Acceptance and Commitment Therapy

The main psychotherapeutic approach utilized by *commit and act* is Acceptance and Commitment Therapy (ACT) (Hayes et al. 1999). ACT is rooted in a philosophical framework called 'functional contextualism' (Hayes et al. 2012a). Within ACT, therapists attempt to understand the functional interrelationships between behavior and contextual/environmental events as well as the learning histories that give rise to and maintain this behavior in order to develop effective interventions. Instead of focusing on the structure or topography of behavior (i.e., what the behavior looks like), clinicians operating from this perspective focus on what is going on functionally (i.e., what has established and is perpetuating this behavior, what its purpose or function is), by conducting a functional analysis. Clinicians ask questions such as 'How did the client come to act or feel this way?', 'What effects or consequences do their actions/behavior produce?', and 'Given our understanding of this, how can we support them to change their behavior?' ACT is closely linked to behavioral analysis and seeks a unified model of behavior change, which provides broad and useful guidance for therapists across a variety of issues (Hayes et al. 2012b). As such, it has been suggested that this approach provides generally applicable principles to the functional analysis of behavior which can be applied across a range of different settings, including diverse cultural backgrounds (Hayes and Toarmino 1995), making it a potentially suitable approach for the purposes of *commit and act's* work. While ACT inevitably carries some degree of cultural biases, its focus on the 'idiographic, functional, and contextual nature of therapeutic work' may help to maximize its therapeutic effectiveness while minimizing the potential negative impact of cultural biases (Pasillas and Masuda 2014, p. 110).

According to the ACT model, suffering develops in part due to two core processes:

1. ‘experiential avoidance’, defined as a lack of willingness to remain in contact with internal experiences such as painful thoughts, feelings and memories (Chawla and Ostafina 2007);
2. ‘cognitive fusion’, whereby behavior becomes dominated by the literal content of one’s thoughts over other sources of behavioral regulation in the environment (Fletcher and Hayes 2005). It is argued that experiential avoidance and cognitive fusion, which are generally referred to as ‘psychological inflexibility’, can lead to emotional distress and to the development of narrow and inflexible behavioral repertoires (Hayes et al. 2006).

ACT uses six core processes (outlined below) to improve ‘psychological flexibility’, which is defined as:

> the ability to contact the present moment more fully as a conscious human being and to change, or persist in, behavior when doing so serves valued ends. (Hayes et al. 2004b, p. 5)

It is suggested that improving psychological flexibility can enhance one’s ability to effectively monitor and evaluate the success of one’s own behavior and may increase sensitivity to the current context in order to modify or develop more adaptive behaviors, that is, behaviors that cohere with one’s chosen values. In order to achieve its objectives, ACT also makes use of mindfulness exercises, paradoxes and metaphors, predominantly through the use of experiential exercises. ACT interventions are typically carried out through one-to-one sessions with a trained therapist or in groups. Self-help resources (e.g., books) can also be utilized.

The Six Core Process of ACT

1. ‘Acceptance’ is introduced as the alternative to experiential avoidance and can be conceptualized as willingness to contact previously avoided events and experiences without attempting to alter their form or frequency, so that the individual can engage more flexibly in behaviors that cohere with their personal values (see below).
2. ‘Contact with the present moment’ involves conscious and flexible contact with environmental and psychological events as they occur.

3. ‘Cognitive defusion’ are strategies that alter or disrupt the literal and behavior-regulatory functions of aversive thoughts and feelings by changing the contexts in which they are usually related to behavior. For example, an individual’s behavior can become governed by the literal content of thoughts like ‘I am stupid’ leading to the consequence of giving up on their studies. This individual could utilize defusion techniques, such as prefacing this thought with ‘*I am having the thought that* I am stupid’, to create ‘psychological distance’ from it, thereby interrupting the relation between thoughts and behavior and increasing behavioral flexibility (e.g., ‘I can have the thought that “I am stupid” and continue studying’).
4. Creating a sense of ‘self-as-context’, whereby one adopts a perspective from which a ‘coherent sense of self is greater than, and distinguishable from, one’s thoughts, feelings, and emotions’ (Foody et al. 2012, p. 130). Self as context is important because from this perspective one can be aware of one’s own flow of experiences without attachment to them.
5. ‘Values’ are chosen qualities of purposive action or life directions (e.g., family, career) that can never be obtained as an object but can be instantiated moment by moment. Although values may vary between cultures and between individuals within the same culture, it is clear that the existence of values is common to all cultures and individuals. According to Wilson and Murrell (2004), values work in ACT:

> has the potential to fundamentally alter our client’s relationship with adversity. Answers to questions about acceptance are always context-dependent. When acceptance of adversity is placed in the context of making a difference in an important life domain, acceptance becomes more acceptable (p. 20)

6. ‘Committed action’ via developing and working toward concrete goals that are values-consistent. ACT encourages the development of larger and larger patterns of effective action linked to one’s chosen values.

ACT has a growing evidence-base of its effectiveness across a variety of problem areas (Ruiz 2010), including anxiety (e.g., Twohig et al. 2006), burnout (e.g., Hayes et al. 2004a), depression (e.g., Zettle and Hayes 1986) and psychosis (e.g., Gaudiano and Herbert 2006). In general, the effect sizes are large and typically even better at follow-up (as measured by RCTs, clinical trials, analogue studies etc.). Moreover, the data seems to suggest that the main processes of change within these ACT intervention studies are those hypothesized, namely reduction of experiential avoidance and cognitive fusion (Ruiz 2010). Also, a growing number of studies have applied very short interventions (e.g., a one-day workshop) that have demonstrated similar effects (e.g., Lillis et al. 2009).

Recently, ACT has been applied to various issues within non-Western populations, such as prevention of long-term disability associated with epilepsy in South Africa (Lundgren et al. 2006) and India (Lundgren et al. 2008), and to chronic headache (Mo'tamedi et al. 2012) and management of Type 2 diabetes (Hoseini et al. 2014) in Iran. Also, some studies have examined the impact of ACT on ethnic minorities within high-income countries such as Asian and Caucasian Americans within the United States (Cook and Hayes 2010). Following their investigation of the practice of cultural competence in ACT outcome research, Woidneck et al. (2012) concluded that while ACT studies have often provided insufficient detail about demographic and other characteristics of their samples (e.g., ethnic or racial information), studies with ethnic minorities provide preliminary evidence that ACT may be effective with diverse groups. Hayes et al. (2011) suggested that successful adaptation of ACT in non-Western contexts may be achieved by adopting a bottom-up functional approach of creating a therapy model from procedures and processes that are linked to basic behavioral principles in conjunction with cultural knowledge and understanding.

Applying ACT in Sierra Leone

ACT, as a behaviorally based and trans-diagnostic approach to psychotherapy, can be applied within various cultural contexts and to a range of different issues. This circumvents potential problems with attempting to apply manualized treatment programs that were developed in the West for specific issues and diagnoses that may not be relevant or valid in the context of Sierra Leone. *commit and act* focuses more broadly on difficulties that are comparatively widespread in Sierra Leone (e.g., trauma, gender-based violence etc.) rather than on particular psychiatric diagnoses. Following functional analyses of these issues and related effects on individuals or groups, ACT techniques can be adapted and applied to promote more adaptive behaviors that serve valued ends and to alleviate suffering and distress.

In keeping with WHO (2010) recommendations and the Sierra Leone Ministry of Health and Sanitation's (2012) mental health plan, *commit and act* is dedicated to ensuring that its services are evidence-based. The evidence-base summarized above makes ACT an appropriate initial choice for providing health care workers with effective psychotherapeutic skills that can be applied to various issues and groups within Sierra Leone. Evidence also suggests that individuals can be trained to deliver ACT as an intervention in a relatively short period of time (Strosahl et al. 1998) and that therapists with limited ACT training can achieve positive therapeutic changes with clients using this approach (Lappalainen et al. 2007). Given the limited resources available to scale up mental health services in Sierra Leone at present, the ACT model can be introduced reasonably quickly via field-based training.

In addition, by working with a variety of professionals (e.g., teachers, religious leaders, social workers), non-specialized workforces, NGO staff and existing groups (e.g., women's groups), *commit and act* aims to increase the amount and range of access points to psychosocial support. For instance, by training teachers and local groups in validated psychotherapeutic methods, children can receive support for various problems by speaking to a teacher who is trained in these methods and adults can access psychosocial support from trained individuals within their local community. *commit and act* aspires to create sources of continuous psychosocial support within communities by working with and empowering individuals and groups to develop structures that provide mental health care by local people for local people. It also aims to promote psychoeducation and reduce stigma so that individuals seek help as and when various difficulties arise, thereby helping to prevent such problems from escalating to a point where the individual becomes severely impaired. *commit and act* also provides ongoing supervision following ACT training so that individuals can further develop and refine their skills and discuss cases with ACT trainers and local ACT experts.

Another important reason why ACT was adopted by *commit and act* as its main psychotherapeutic approach is due to evidence which suggests that ACT training can have a positive impact both professionally (Hayes et al. 2004a) and personally (Luoma and Vilardaga 2013) on individuals who undergo this type of training. Typically, ACT training consists of a combination of didactic presentations and experiential exercises where therapists engage in ACT processes in an effort to increase their own psychological flexibility (see Luoma et al. 2007). Hayes et al. (2004a) found that ACT training had a positive impact on stigma and burnout for substance abuse counselors and that follow-up improvement with regard to burnout exceeded those of cultural competency training alone (i.e., training designed to help counselors become aware of their own biases in areas such as culture and race). Luoma and Vilardaga (2013) observed improved conceptual knowledge, increased psychological flexibility and reduced burnout in therapists on validated self-report questionnaires post-ACT training and at follow-up. Given the increased burden on health care workers in Sierra Leone due to the lack of training, limited resources and low pay (Song et al. 2013), there is an increased risk of burnout for health care professionals. Thus an important component of improving the health care services and their sustainability should involve the promotion of self-care for health care staff.

The Development of *commit and act*

commit and act was first established in 2010 by Beate Ebert, a psychologist from Germany and co-author of this chapter. It began with the wish to contribute to the field of psychotherapy in LICs and areas of conflict after a friend, whose birth father was Sierra Leonean, informed Beate of the atrocities that the people of Sierra Leone had experienced during the civil war and of the lack of medical care and psychosocial support. Based on the vision that human beings are able to experience their natural love, relatedness and greatness independent from their experiences in the past or from actual impeding circumstances, *commit and act* was founded to help people in Sierra Leone and other areas affected by conflict. The aim was to train local health workers in effective psychotherapeutic methods like ACT so that they could adapt these techniques according to their needs and culture and provide appropriate support for their people. From the outset, *commit and act* was of the mindset that training should be delivered in a context of partnership, with the idea that that this would provide an opportunity to learn from each other in a mutually beneficial way.

Before the training began, an initial visit to the country was conducted to explore the needs and concerns of the local people and how to best support them. During this visit, discussions were held with various stakeholders (e.g., NGOs, religious leaders, local people) and important connections to existing structures in the country were established, such as NGOs led by local people who encouraged the endeavor and supported the approach. They assisted *commit and act* with organizing the ACT training workshops by utilizing their existing infrastructure (e.g., identifying suitable locations for training and local organizations who might attend). *commit and act* generated the initial funds for this work through friends, family and other private donors. Given the lack of resources in Sierra Leone, it was necessary for *commit and act* to cover the costs of local therapists' travel, food, accommodation, the venue and materials. Regular supervision would be given online by experienced ACT trainers and by local counselors within the country to provide ongoing support following training and to ensure sustainability of the project. In addition, particularly engaged therapists who wanted to become ACT trainers would be supported to attend Association for Contextual Behavioral Science conferences to receive advanced ACT training.

The First ACT Training Workshops

After discussions with local people about common practices for workshops in Sierra Leone, two three-day ACT beginners' workshops with groups of around 30 participants each were conducted: one in Freetown and one in the countryside (Bo), to incorporate more remote areas of the country. Two to three counselors from a range of local organizations were invited so that participants could continue to assist and support each other after the workshop. As there were no existing guidelines about how to apply ACT in an African culture (or in non-Western cultures in general), the workshop format comprised didactic instructions led by facilitators with role plays in front of the group and then dividing them into small groups to practice. Participants were invited to share specific problems that they wished to address, and they were also encouraged to modify ACT techniques (e.g., metaphors) according to their cultural context. The overall focus was on assisting participants to develop broadly applicable skills and to adapt the ACT techniques introduced during training so that they could better support local people to live their lives according to their personal values and to deal flexibly with possible constraints from the past or in the present, while acknowledging their history and current circumstances. The workshops centered around three main ACT processes: (1) acceptance of circumstances, feelings and so on that cannot be changed (e.g., war-related experiences, poverty), (2) taking new perspectives on oneself and on life situations, like the perspective of being whole and complete versus being damaged (which individuals affected by trauma might experience) and (3) becoming aware of valuable directions in life and to act according to them. These processes were presented in a mainly experiential way with some didactic parts. Participants were encouraged to consider whether they found the processes helpful for themselves and for their work with clients.

Language was potentially an issue as English was not the first language for most participants or for some of the ACT trainers. However, trainers made concerted efforts to communicate clearly and to repeat important information, and participants did not report any language barriers. The metaphors that are typically used in ACT did not always apply to the Sierra Leonean context (e.g., 'being on autopilot'). Participants were creative in modifying and inventing metaphors, which were topographically different but functionally the same. They also created their own metaphors. For example, 'make your sad thoughts your friends' ('make then you mind padi' in Krio) was developed by participants to help clients who become entangled or 'fused' with their thoughts and expend a lot of energy struggling to change or avoid them to adopt a new perspective or strategy, namely acceptance.

The participants easily translated their new knowledge and experiences into the local context and applied it to their personal concerns and their clients' needs. One participant who attended the initial training workshops, a qualified social worker, experienced counselor, and co-author of this chapter, Hannah Bockarie, relays her experiences of the first ACT training workshop below. Hannah has since become *commit and act's* local partner in Sierra Leone.

> I had been struggling with a personal sad experience for many years as I had been caught by the rebels during the civil war. When I attended the ACT training with *commit and act*, I came with an open mind as I hoped to find something valuable in this workshop that would help me. On the first day of the workshop I shared my experience with my colleague who had come with me. He encouraged me to open up and so I began to use the mindfulness exercises that I had learned in the workshop. I had not done mindfulness before and I practiced working with the mind instead of pushing the mind. As I did this

> I realized that the thoughts were just there and I could simply observe them instead of struggling with them like I had before. I made them 'my friends' instead of putting all my effort and strength into putting them off me. I practiced it more and more and it became easier for me. After the three-day workshop I experienced a drastic change. I began to relate to life in a different way. Over time and with more ACT training and applying to it myself and my work, I developed willingness to face difficult thoughts and feelings, and acceptance to allow them and to give them space. I became more flexible as my actions became less influenced by my thoughts and feelings and more by my values.

Examining the Impact of *commit and act*: Dealing with Cross-cultural Issues

One of the strengths of *commit and act* is that it has an established research component. Through collaboration with the Global Mental Health Masters program at the University of Glasgow in the UK, students have worked with *commit and act* to investigate various issues within Sierra Leone and to evaluate the impact of its work. One student has worked with *commit and act* to develop an ACT training manual for the Sierra Leonean context (*commit and act* 2014). Another student has conducted qualitative interviews with participants who attended training to explore how ACT influences NGO staff's work with clients and whether they thought that adaptations needed to be made to the approach (Mays et al. 2013). The team has also evaluated the impact of ACT training on participants using validated questionnaires that measure ACT constructs such as psychological flexibility (Acceptance and Action Questionnaire-II [Bond et al. 2011]) and valued living (Valuing Questionnaire [Smout et al. 2014]), and related constructs such as life satisfaction (Satisfaction With Life Scale [Diener et al. 1985]). Findings from this study indicated improvements in psychological flexibility and life satisfaction following ACT training at post-workshop and at 16-weeks follow-up, including for individuals who reported traumatic symptoms (Stewart et al. 2016). Future research will involve investigating local idioms of distress and important day-to-day activities so that culturally sensitive measures of distress and related impact on functioning can be developed to examine the acceptability and impact of ACT interventions for this population.

In order to examine understanding and adherence to the ACT model, *commit and act* has monitored participant trainees during training exercises (e.g., role plays), supervision and also in their professional work. During early training workshops, it was observed that some participants tried to comfort or advise clients, which from an ACT perspective can lead to increased avoidance, and this issue is now often addressed in beginners' training workshops. In the context of supervision meetings, counselors present cases from their daily work and examine them from a functional perspective. The group then discusses how ACT techniques might be utilized. In vivo sessions between local counselors and their clients have also been observed. For example, in one observation session, a school counselor was working with a street kid who had exhibited feelings of frustration and aggressive behavior after his parents died. He had begun to carry a knife which he used to threaten and rob others. Following a functional analysis, it became apparent that the purpose of this behavior was to give him a sense of power, control and security. The Life

Line exercise (Dahl et al. 2009) was used to help the client explore his values (he wanted to become a doctor to prevent people from dying like his parents had). The counselor worked with him to cope with his difficult emotional content (e.g., anger, sadness, loneliness) and to make the connection that studying to become a doctor would require the committed action to abandon the control strategy and to give the knife to his counselor, which he did one day later.

Cultural Considerations

Religion is important for people in Sierra Leone, which is about 77% Muslim and 21% Christian (U.S. Department of State 2013b). Official events (including *commit and act's* training workshops) begin and end with prayers (both Muslim and Christian) and religious songs. Community life and religious expression are intrinsically tied together, and religious values are closely linked with community and personal values. For instance, prayer has been a source of comfort and coping with the aftermath of the civil war (Brown 2013). Also, rituals conducted by religious or traditional leaders that combined prayer, song and dance have been used to facilitate reintegration of returning child soldiers into their communities (Denov 2010) However, religious behavior can sometimes be used as a strategy for emotional avoidance and control which can influence and occasionally restrict emotional expression. For *commit and act*, it is important to be respectful of local religious beliefs and values, to understand how local interpretations of religious beliefs and values may influence self-expression and emotional regulation, and to evaluate whether the emotional regulation strategies employed by an individual with regard to a particular issue is adaptive (i.e., recognizing the function and workability of the behavior). For example, in one training workshop a Christian nun shared that her sister had died a few days before and that her family had told her not to cry as this demonstrated a lack of trust in God's will. She expressed gratitude that the experiential components of the workshop validated her grief and permitted her to express it freely. From an ACT perspective, religious and spiritual values can be powerful in affecting change in many areas of clients' lives and can meaningfully interact with the other values in their lives. However:

> religion/spirituality, like other valued domains (e.g., relationships, work), is most powerful and adaptive when it occurs in a flexible, values-driven manner. (Murrell et al. 2014, p. 173)

Also, participants who attended the *commit and act* training workshops reported that within some Sierra Leonean ethnic groups (e.g., Temne, Mende), there is a restricted vocabulary with regard to emotional words. For example, in Mende culture the word 'bad' is often used to express negative affect, but this could refer to feelings of sadness, frustration, anxiety and so on. Instead, people express distress in terms of its impact on behavior. For example, 'I feel so bad that I cannot go to the marketplace'. Thus another important point of ongoing discussion relates to cultural differences (even within Sierra Leone) regarding emotional expression and how this might affect therapeutic interactions with these clients. The relationship between culture and emotional expression and regulation is a complex one (Ford and Mauss 2015), and it will be important to revisit this topic as ACT spreads within Sierra Leone.

Improving knowledge of local issues and various perspectives on them has been an important and ongoing part of *commit and act's* work, and they have endeavored to do so by communicating with local services (e.g., Police Service Family Units, rehabilitation centers, Kissy Mental Hospital), communities (e.g., men and women's groups, tribal chiefs) and NGOs. Nonetheless, some cultural barriers with regard to local customs and attitudes have arisen in this work. For instance, gender-based and domestic violence have become key issues for *commit and act* however, this work can prove challenging as traditional gender roles whereby women are expected to obey their husbands and to tolerate abuse are often culturally ingrained. In keeping with the organization's values that the integrity of every human being must be respected, violence is never acceptable, and it can be difficult to avoid judgment based on one's own values and cultural background. One way of ensuring that the team remains open and understanding with regard to contentious issues like domestic violence is by conducting a functional analysis of them (i.e., understanding the contextual factors that have led to their establishment and maintenance) and discussing the values of those affected by them. Exploring values creates common ground for discussion as values are something that is relevant to every individual and culture. Moreover, the ACT therapeutic posture entails 'an accepting, loving, compassionate, mindful, and creative relationship between two conscious and transcendent human beings, who are working together to foster more committed and creative ways of moving toward valued ends … effectiveness over self-righteousness' (Pierson and Hayes 2007, p. 225). By adopting this posture, this facilitates connection with others and helps create a context in which people feel safe and supported to explore more effective ways of behaving in accordance with their values. A case example of how ACT and other related techniques have been used to deal with domestic violence is presented below.

Case Example: Domestic Violence

commit and act conducted a PROSOCIAL (see www.evolution-institute.org) intervention workshop with men and women in Bo using an ACT tool called The Matrix (Polk and Schoendorff 2014). PROSOCIAL is a framework for improving the efficacy of groups and offers a practical and flexible structure for establishing group identity, clarifying shared values and goals, and enhancing group functioning and effectiveness in the service of their values. PROSOCIAL incorporates the functional contextual approach into its framework and utilizes ACT processes and the Matrix to improve the psychological flexibility of groups and individuals. The Matrix simplifies ACT processes and provides a broadly applicable and replicable format that allows therapists to improve psychological flexibility with individuals and groups in a short space of time and in various settings (e.g., within the community). The four quadrants of the Matrix provide a basis for discussing the group's values and goals, mental experiences that obstruct valued goals, actions that follow from these mental experiences and actions that move the group toward its values. The Matrix is also used within *commit and act's* training workshops to help participants with case conceptualisation and formulation. In one study, over 70% of participants reported using the Matrix in their work with clients at follow-up after training (Stewart et al. 2016).

The aim of this intervention was to provide an open and safe environment for women and men to examine their marital relationships and, more specifically, to reduce domestic violence by creating shared values. During the workshop, both men and women identified similar values, such as loving and caring for their families and ensuring that their children receive a good education. However, stress and feelings of frustration, sadness and disempowerment (especially for men) were recognized as barriers to these values. Men reported struggling with feelings of inadequacy when they were unable to provide for their families due to low-paid work or unemployment and often rely on their wives to do so. Women reported that men did not tell them how much they earned or allocate enough money to feed the family. These issues strained marital and family relations as it led to increased arguments and some men resorted to drinking, violence and infidelity.

Participants were invited to take part in role plays to demonstrate typical interactions where men behave aggressively and women criticize men. They were then invited to demonstrate another interaction but this time in a 'friendly way'. By altering the context participants became more aware of the consequences of their typical behavior. They then identified shared values such as having an equal, peaceful and loving relationship. Finally, participants decided to monitor their behavior (e.g., number of arguments, time spent together, decisions made as a couple etc.) and to meet again as a group one month later. At this time, not only did participants indicate reductions in previous behaviors (e.g., arguments, violence) but also they reported a variety of new behaviors, such as discussing finances and making decisions together, men arriving home earlier, eating and spending time together as a family, improved sexual relations and openly expressing love and gratitude for each other (e.g., men bought gifts for women).

By reaching an understanding of the function of men's aggressive behavior and exploring personal and shared values, a new context was created that helped participants identify alternative behaviors that cohered more with their values. Participants demonstrated improved psychological flexibility (e.g., willingness to let go of past behavior and memories) and an increase in their behavioral repertoires. For example, when men agreed to stop using coercive or violent behavior and to discuss household decisions with women, participants reported improved marital relations and new behaviors (e.g., giving gifts, spending more quality time together) which will likely reinforce these new behaviors.

Empowering Local People: Fighting Ebola in Bo

Empowering local leaders and communities and working with various organizations (e.g., government departments, NGOs) within the local context are important pillars for the sustainability of this work and for ensuring that it remains culturally sensitive. Hannah Bockarie has become a skilled therapist, trainer and the director of *commit and act* in Sierra Leone. She spearheaded the development of a center for *commit and act* in Bo where local people receive individual and group counseling, psychoeducation and ongoing training and supervision. This has also helped Hannah to empower other groups through her work (e.g., local women's groups) and to make important connections with leaders in the area of politics, media, education and so on.

Empowering local communities has been particularly important in recent efforts to prevent the spread of Ebola in Sierra Leone. *commit and act*, under the leadership of Hannah, has adopted a pragmatic approach in their efforts to tackle Ebola by training local people in broadly applicable practical models and frameworks, such as ACT, PROSOCIAL and simple therapeutic tools (e.g., the Matrix). As mentioned previously, these methods can be taught in a relatively short period of time and can be used effectively by participants with very little training. Hannah trained dozens of health care workers, volunteers working in quarantined areas, women's groups, Paramount Chiefs and teachers working within every section in Bo in the PROSOCIAL framework. These groups have used this training to provide psychosocial support for local communities, educate them about Ebola, clarify their shared values and to encourage them to engage in effective values-consistent behavior change to prevent the spread of Ebola. For instance, in some communities, people identified that their values are to keep their community safe but they also value honoring their dead via traditional burial rituals and funeral services. However, following information that people are most at risk of contracting Ebola during these burial rituals where they wash and kiss the body of the deceased, the community agreed to give the dead bodies to the WHO-trained burial units and to replace the body with the trunk from a banana tree. In this way, the community created their own solution to this serious problem and were supported to modify their behavior to protect their loved ones while still honoring their dead and preserving their most important customs.

Implications for Global Mental Health Policy and Practice

ACT, as a therapy rooted in functional contextualism, may offer broadly applicable behavioral principles that can be applied across a variety of different issues and thus may have merit in culturally diverse contexts. Applying cultural knowledge to ACT procedures and processes may enhance this approach within the Sierra Leonean context (e.g., by modifying metaphors so that they are more culturally relevant). The ACT model may be particularly advantageous for a number of reasons:

1. There is a drive for more evidence-based services. ACT has a growing evidence-base across a range of issues (Ruiz 2010), and preliminary evidence suggests that it may be effective with diverse groups (Woidneck et al. 2012);
2. From the practical perspective of trying to scale up and improve access to mental health care services, the ACT model is clinically effective, it can be readily introduced through field-based training, and therapists can achieve good outcomes with clients with relatively little training using this approach;
3. ACT training can lead to positive outcomes both personally and professionally for therapists. Findings from Stewart et al. (2016) have indicated that

> ACT training may have a positive impact on participants' well-being in a Sierra Leonean context. Promoting self-care and preventing burnout will be an important component of sustaining mental health services in Sierra Leone.

Connecting and collaborating with established services is crucial, particularly for NGOs from other cultural backgrounds who aim to provide psychotherapeutic support in these contexts. *commit and act's* experience has highlighted the value of conducting extensive research about an area, its needs, potential cultural issues, existing services and other considerations, before one can determine the most appropriate way of providing support. Given that Sierra Leone has limited mental health care services and that staff are overburdened and lack sufficient training and resources, a number of vital components are needed for scaling up services in this context, including: (1) community-based approaches to training and delivering psychosocial support; (2) working with a range of different professionals, non-specialized workforces, and local people; (3) utilizing validated psychotherapeutic approaches (e.g., ACT); and (4) providing ongoing supervision and support so that individuals can develop their skills across time. By working with individuals from a range of sectors (e.g., schools, prison services, NGOs etc.), the number of access points to psychosocial support have increased, improving access to mental health care within the community. It is also hoped that over time and with increased use of these services, this will help to reduce stigma surrounding mental health issues in Sierra Leone.

Finally, by empowering local people to pursue their goals and vision, as individuals like Hannah have done, the possibilities for how this approach can be applied to various issues increase exponentially. However, government support is needed to further facilitate this. The Sierra Leonean government has made important strides in addressing mental health issues and identifying areas that must be targeted to better support people affected by mental health difficulties and their families and communities. It is imperative that the government collaborates with existing health care providers and NGOs and supports them to continue in their efforts to provide the best level of care for its population. One essential aspect of this will be to conduct ongoing research that examines the impact and effectiveness of current efforts, explores other issues and at-risk groups, and continues to inform best practice. While *commit and act* has made an important contribution in this context, greater efforts must be made to train up local researchers within Sierra Leone and to support their efforts so that there is a continuous process of improvement in relation to mental health care in the country.

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Globalisation of Pesticide Ingestion in Suicides: An Overview from a Deltaic Region of a Middle-Income Nation, India

Sohini Banerjee and Arabinda N. Chowdhury

The World Health Organization (WHO) estimates more than 800,000 people died by suicide in 2012 (WHO 2014). Suicide is the leading cause of death in 15–29-year-olds across the world. However, there is a variation in the pattern of substances used in self-harm. Globally, consuming pesticides, hanging and firearms are the most universal methods of suicide (WHO 2014). At a time when poisoning due to medicines and drugs is a cause of alarm in industrialised nations, testimonies of increased pesticide poisoning are being reported from LMICs (Gunnell and Eddleston 2003). Pesticide poisoning and deliberate self-harm (DSH) is now considered as a major public health problem in LMICs (WHO 2004). Furthermore, an epidemic of farmers' suicide by pesticide ingestion is emerging as an agrarian crisis in India (Das 2011).

Pesticide ingestion is increasingly becoming a popular method for attempting and committing suicide. All across the world, approximately 300,000,000 cases of pesticide poisoning occur each year leading to more than 250,000 deaths. These deaths comprise a significant portion of 900,000 people who die by suicide every year. These casualties occur predominantly in rural areas of several Asian communities (WHO 2006). Estimates indicate that

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approximately 60–90% of the suicides in the last decade in China, Malaysia, Sri Lanka and Trinidad were due to pesticide ingestion (WHO 2006). The WHO reported that there has been a rise in pesticide-related suicides in Asia, Central and South America (WHO 2006). Globally, pesticide ingestion accounts for approximately one-third of all suicides (Gunnell et al. 2007). Furthermore, there is global variation: 4% in the European region; 56% in Western Pacific region; (Gunnel et al. 2007) and over 60% in rural South-East Asia (Gunnell and Eddleston 2003). In SE Asia as a whole it is estimated that more than 160,000 people committed suicide by ingesting pesticides (Gunnell et al. 2007). This has very serious financial implications on the health services of LMICs. An estimated cost of treating self-poisoning cases in Sri Lanka in 2004 was about $1 million (Wickramasinghe et al. 2009).

This chapter examines the following issues: the easy availability of pesticides in the geographically remote deltaic region in Eastern India, viz., the Sundarbans; the aggressive marketing by pesticide companies, the limited role of the local administration in the sale of pesticides, and specific sociocultural contexts in which pesticides are consumed to attempt self-harm.

In the next section, we intend to discuss briefly the prevailing pesticide scenario in the world.

Part I: Pesticide: Global Scenario

The US Environmental Protection Agency (2012) defines pesticides as substances or combination of materials for preventing, destroying, repelling or mitigating any pest (living creatures that harm crops, human life or other animals). Pesticides comprise a variety of substances including insecticides, fungicides, herbicides, rodenticides, molluscicides, nematicides, plant growth regulators and others.

Pesticides are one of the most important agents used for crop protection. The agricultural scenario in Asian countries underwent remarkable change after the Green Revolution in 1960s. Production has increased many fold because of the use of high-yielding seeds and quality fertilisers and thus pesticides ensured both guarantee against crop failure and increased agricultural yield. Policy makers sought to underscore the positive aspects of pesticides while largely obscuring its potential dangers. This made pesticides easily accessible and affordable at the farm level (Pingali and Roger 1995). Consequently, a lucrative international pesticide market emerged. Across Asia, pesticide use increased from $347 million in 1980 to 1.079 billion in 1990, an average annual increase of 20% (Rola and Pingali 1993). The global pesticide industry is expected to reach $68.5 billion by 2017 with an average annual growth rate of 5.5%, but with a higher rate in South America and Asia. Pesticide sales increased 289% between 2000 and 2010 (Rojas 2011). The collective pesticide market revenue for India, China and Japan reached $11.7 billion in 2011 and is expected to reach $16.2 billion by 2016 (China Agrochemicals 2012). The irony of the situation is that while LMICs continue to be the largest pesticide users, the global pesticide production market was dominated by ten companies, all of which were from industrialised nations. The overwhelming majority of 89% of global sale of pesticides in 2008 were shared by these ten companies (ETC Group 2008). The ensuing reality from this global spread and consumption of pesticides is that about two-thirds of the inhabitants in the LMICs are exposed to varieties of dangerous chemicals that may be harmful to their health and environment and are used for poisoning which has become an important cause of morbidity and mortality in these countries.

The next section aims to draw attention to three issues in an agricultural community in the Sundarbans Region, India: the Panchayat's (local government's) role in pesticide regulation, farmers' pesticide practices and review of hospital records of pesticide-related DSH/suicide cases over a one-year period (2007–2008). This study proceeded from Keith Hawton's definition of DSH mainly that it refers to an act of non-fatal DSH, without attempting to judge the lethality of intent in applying the term (Hawton et al. 2002). Suicide was defined as a DSH with a fatal outcome.

Part II: Pesticides and DSH: Experience from the Sundarbans Region, India

The Sundarbans region and the Panchayat

Sundarbans is one of the world's largest deltas at the mouth of three rivers, viz., the Ganges, Brahmaputra and Meghna, which converge at the basin of the Bay of Bengal. It covers an area of 10,284 km^2 of which three-fifth is in Bangladesh and the remaining in India. The Indian region comprises 19 Development Blocks (13 under two districts of West Bengal state: South 24 Parganas, and 6 under North 24 Parganas). The Sundarbans region of West Bengal is a geographically remote and socio-economically underdeveloped area as compared to the other districts of the state. Poverty, illiteracy, and poor communication and transportation network with the mainland have contributed to poor quality of life in the region. Though health services such as Primary Health Centres (PHCs), exist in the region, nevertheless, these continue to be out of reach of people living in the far-flung areas. The region is bereft of mental health services (Chowdhury et al. 2001).

Panchayat and Pesticide related DSH/Suicide

In view of the spirit and recommendation of the Balwant Rao Mehta committee and the West Bengal Panchayat Act, a three-tier Panchayat or local government system was established in 1978 for the development of an effective rural development strategy for the whole state of West Bengal. The bottommost tier is the democratically elected Gram Panchayats (GP), operating at the village level. This is made up of a number of villages or *mouzas*, and the members are democratically elected by the constituent villagers. They are the executive bodies entrusted to implement the overall developmental programmes for the welfare of the villages (Mitra 2015). Panchayat Samity at the block level constitutes the middle tier. The third and highest tier is the Zila Parisad, at the district level. The block developmental officer is the ex-officio, executive officer of the Zila Parisad of a district. Each Panchayat body of any tier is a unit of self-government and is democratically elected. Members enjoy a certain level of autonomy in terms of article 243G of the Indian Constitution. The number of GPs in a block, or the number of members in each tier, or the proportion of reserved seats in each tier is determined by state government from time to time by notification. The Indian central government has a separate ministry for this called the Department of Panchayat Affairs & Rural Development. Panchayat is thus the elected democratic body who represent the people of the community. The Panchayat often acts as the gatekeeper in any village, and including the perception of the Panchayat Samity and the GP on any issue is of utmost value in understanding community views of the problem and in developing a culturally appropriate intervention programme.

Study of Panchayat members' and farmers' perceptions of pesticides and DSH/suicide

DSH and suicide by pesticide consumption is a serious public health problem in many agricultural communities and the Sundarbans region is no exception. A pilot study among the 13 community Developmental Blocks of Sundarbans under South 24 Parganas district revealed extensive mortality and morbidity from pesticide poisoning (Chowdhury et al. 2007; Banerjee et al. 2009).

This study aimed to elicit the Panchayats' and farmers' perception about the nature and extent of pesticide use, the former's role in regulating and promoting safe pesticide use and the epidemiology of pesticide use in DSH/suicide in the region. This study also explored the different psychosocial dimensions that acted as proximal risk factors for self-harm in vulnerable individuals admitted to hospital. The Namkhana Block, under South 24 Parganas district, was selected as the study area. Most of the inhabitants of this area are Hindus (88%). It has seven GPs. The Panchayat Samity is located at Namkhana, the village bearing the same name as the Block. There are 110 members in 7 GPs and 26 in the Panchayat Samity. The research questions included:

1. Is the easy availability of pesticides in the region facilitating the increase of intentional self-injury behaviour and consequently emerging as an important public health issue in the community?
2. Are pesticides replacing other traditional methods (burning, drowning, and hanging) of self-harming behaviour?
3. Do farmers practice and adhere to standard safety rules of pesticide use and custody?
4. What are the specific sociocultural contexts other than mental illness that prompts self-harming impulses in the local population?

The study was conducted in four stages. First, a focus group discussion (FGD) was conducted in each of the seven GPs, in the Panchayat Samity, and with farmers to explore perceptions about mental health and DSH/suicide. Secondly, information was collected through semi-structured questionnaires completed by Panchayat members and farmers. Thirdly, in-depth interviews were conducted with farmers. Finally, a case register was designed for Block Primary Health Centres (BPHCs) to record details of incidents of DSH/suicide and in-depth interviews were conducted with people who had attempted self-harm and family members.

FGDs with Panchayat members:

124 Panchayat members participated in FGDs. The major findings are summarised in Table 32.1.

Panchayat members' questionnaire:

124 GP members completed the questionnaire, including members of Panchayat Samity of Namkhana block. An overwhelming majority (95%) of the GP members knew someone who had consumed pesticides with the intention of harming him/herself. Pesticide consumption was acknowledged to be a health problem by 86.3% of the members. Of the 124 GP members

Table 32.1 GP and Panchayat Samity members FGD findings

- GP and Panchayat Samity Members' Perceptions About DSH/suicide.

All GP and Samity members acknowledged that DSH and Suicide is a major public health problem in the region.

Nearly all (98%) members were of the opinion that pesticide ingestion was replacing other methods of self-harm like hanging and burning.

A little less than three-fourth (72%) said that more women are attempting self-harm as well as a result of social injustice, oppression and discrimination.

Nearly 81% of the members alleged that demand for dowry, domestic violence, spouses' extramarital affairs, alcoholism, economic distress, broken love affairs and failures in examination were commonly reported reasons for attempting self-harm.

DSH was perceived to be a behaviour adopted to seek attention or to escape from a distressing situation by 32% of the GP and Samity members.

Eighty-five per cent of the GP and Samity members expressed that BPHCs and PHCs of the region were not always well equipped to ensure prompt management of the poisoning cases.

87% of respondents stated that collaboration between the Panchayat and various government departments such as health, agriculture, and the Public Works Department to address the issue of pesticide poisoning would yield better results

- GP and Panchayat Samity Members' Views on Pesticide Practices in the Community.

Ninety-one per cent of the respondents reported noticing increased dependence on pesticides for agricultural practice.

All (100%) members said that the number of shops selling pesticides has increased over the years, and that these shops did not possess a proper license to sell pesticides.

Nearly all (97%) reported the Panchayat's limited role in the regulation of pesticide sales in the region.

More than three quarters of the members said that farmers had little or no knowledge about the safe use and custody of pesticides.

who responded, 88.7% of the members were of the opinion that the GP could play an active role in the DSH-/suicide prevention programme by training farmers on safe pesticide practice in collaboration with the agricultural department, generating awareness in the community about issues that may lead to domestic violence and by imposing stringent rules on pesticide sale. Approximately 80% of the members felt that the GPs should be empowered to regulate pesticide sales which in their opinion would strengthen the GP's role in controlling pesticide-related self-harm. However, all members unanimously acknowledged that although they wished to have more autonomy in regulating pesticide sales, nonetheless they were not empowered to do so. A little over three-fifths (62%) of the members conceded that they were unaware of the total number of shops selling pesticides in their respective

Table 32.2 Farmers' FGD Findings

An overwhelming majority (92%) of the respondents opined that farmers lack proper knowledge about safe pesticide practices including use and storage, which lead to deliberate self-poisoning or accidental poisoning.
Approximately all (98%) farmers reported pesticide shop owners continued to be the only source of information about pesticides.
More than three-fifth (65%) of the farmers expressed that banned and spurious pesticides continued to be marketed.
All farmers (100%) felt they needed proper education and training on safe pesticide practices and Panchayat intervention in supervision of the local pesticide market.
The active involvement and participation by the Block Agricultural department in imparting advice on agriculture and pesticides to the farmers was advocated by 97% of the farmers.

areas. Approximately one-third (32%) of the GP members said that they participated in dowry-related[1] dispute arbitrations in their respective villages.

FGDs with farmers:

Seven FGDs formed from different farmers' groups from seven GPs were conducted (N = 62). Each FGD was tape-recorded with participants' consent and transcribed and analysed. The major findings are presented in Table 32.2

Farmers' questionnaire:

A 20-item Bengali-language questionnaire investigated farmers' attitudes to pesticide use and DSH. It enquired about pesticide practices, viz., nature of pesticide use, storage, knowledge about danger of pesticide use, health hazards of pesticide use and any accidental and deliberate poisoning in the household. Twenty farmers were selected on the basis of their willingness to respond

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[1] The custom of dowry in Indian marriages is a deep-seated cultural phenomenon. India's Dowry Prohibition Act of 1961 defines a 'dowry' as 'any property or valuable security given or agreed to be given directly or indirectly by one party to a marriage to the other party, or by the parents of either party to a marriage' (Ministry of Women and Child Development 1961, p. 5). As a cultural practice the dowry system propagates domination, torture and killings of women (Adegoke and Oladegi 2008). Despite laws prohibiting the practice, there has been little change in India. In the last three decades, brutality against women in the name of dowry seems to have risen. Social activists, sociologists and cultural anthropologists have indicated that the dowry system has serious implications for women in India in the sense that it advances discrimination against the female child in the form of infanticide and sex-selective abortions (Das Gupta and Bhat 1997). In the context of dowry and son-preference, female children are believed to be an economic liability and are subjected to differential treatment with regard to food, shelter and educational opportunities (Arnold 1992). Violence towards a bride which results in her death is called a "dowry death" or "dowry murder" (Rudd 2001). A suicide committed by a bride who is mentally and/or physically pressurised to pay dowry is also classified as a dowry death. The first national law was The Dowry Prohibition Act of 1961. Following this law, the Dowry Prohibition Amendment Act of 1984, the Criminal Law Act of 1983 and the Protection of Women from Domestic Violence Act, 2005 are laws in India that aim to address the issue of dowry and protect women. However, a number of loopholes in each of the laws have rendered them largely ineffective.

from each GP and thus a total of 140 responses were collected, from which 18 responses were rejected because of incomplete answers resulting in 122 responses. In addition the FGD participants (n=62) also completed the questionnaire and were included in the analysis bringing the total to 184 (122+62).

Of the 184 farmers who completed the questionnaire, the majority (88.04%) reported possessing cultivable land and only 22 (11.95%) cultivated others' land. All farmers reported using pesticides. More than half (98, 53.23%) of the farmers using pesticides reported storing it inside the house. Of those storing indoors, 91 (92.85%) reported storing it in a box. Only a small number (7, 7.14%) stated that they did not keep it in a box. Less than half (42, 46.15%) the farmers had provisions for storing pesticides in locked boxes. The remaining 49 (50.00%) did so in open boxes. Respondents primarily expressed concerns about the safety of children, and thus 90 (91.83%) farmers indicated storing pesticides in places that were out of reach of children. Forty-five (25.46%) farmers reported storing pesticides outside the house and 12 (26.66%) reported storing it elsewhere. Only 61 (33.15%) were aware of whether the shops selling pesticides possessed a valid license. The rest (123, 66.84%) reported not knowing about the nature of the shop. One hundred and ten (59.78%) of the farmers purchased pesticides a week before use. Only 42 (22.82%) declared buying it on the day of application. Others either bought it a day (24, 13.04%) or a week (8, 4.34%) in advance. 116 (63.04%) farmers had knowledge on ill-effects of pesticides on crops, while the remaining 68 (36.95%) were unaware about the deleterious effects. They gathered information primarily through fellow farmers (30, 35.29%), the agricultural department (20, 23.53%), pesticide shops (18, 21.18%), own experience (11, 12.94%) and pesticide companies (6, 7.06%).

The majority of participants (134, 72.83%) had experienced discomfort while spraying pesticide, the most frequently cited form of discomfort being headache (44, 32.84%). Intentional self-injury by pesticide consumption was reported by 161 (87.50%) of the farmers. Just under 77% (141, 76.63%) believed that self-harm by pesticide ingestion could be reduced by adopting appropriate programmes such as public awareness generation about the dangers of pesticide use, circumstances in which pesticides may be consumed (48, 34.04%), farmer's training (84, 59.57%), including safe storage of pesticides and reducing domestic violence. Sixteen (8.7%) farmers reported DSH incidents in their families among which two (12.5%) deaths had occurred.

In-depth interviews with farmers:

A total of 39 in-depth interviews were conducted with farmers in different villages of Namkhana. The interviews were designed to address four important areas of pesticide practice, viz., pesticide selection, storage, precaution in use and health effects of pesticides. Interviews were recorded with the permission of the participants. Recordings were later transcribed and manual content analysis was carried out to identify common themes/issues. Some examples of a brief transcript on each issue are given below.

Reflecting on the topic of pesticide selection, Mr SG, 42 years, from Fraserganj GP, said:

> How can we know about the details of the pesticides? We are illiterate. We mainly ask the pesticide shop owners about the type of pesticides for a particular type of crop and they give us what is required. We have to believe them blindly because most of us can barely read and understand the instructions written on the packet, mostly in English and in tiny print. Yes, sometimes we don't get the desired results and we report to the shop owner. They say that they cannot help us. The pesticide companies said that a particular brand is suitable for a particular crop and they advised us accordingly. No one wants to take any responsibility. If we argue, then they ask us to lodge our complaints with the company dealer. But, we have not met any company dealer. Sometimes, we also take the advice of our fellow farmers. We are eager to know if someone has a good harvest, what pesticide he used. I haven't seen any KPS (Krishi Prajukti Shahayak-agriculture welfare officer) in our village in the recent past. We are not getting any help from either the local agriculture department or the Panchayat. We rely on our common sense.

With regard to pesticide storage, Mr NM, 45 years, from Dwariknagar GP, said:

> I am a share-cropper. I have to hand over half of the produced crops to the owner of the land. I use different types of pesticides. How can I tell you the names? Each year the market is flooded with new pesticides! I can't tell you the names. I keep the pesticides in a wooden box in my cowshed. I have only one room—how can I keep it secretly? It is not a secret place. The children do not have access to the pesticides, but my wife does. I am aware of the risk of suicide by consumption of pesticides. There have been two such incidents in our village during the past year. Whenever I quarrel with my wife, I immediately hide the pesticide packet so that she cannot find it. Farmers in the region are mostly living in a one room thatched cottage with a cowshed- there is no separate room to hide pesticides.

Expressing his precautionary views on pesticide use, Mr CG, 32 years, from Sibrampur GP, said:

> What precaution we will take? We don't receive any safety devices like gloves or mask from the shop. These may be available if you purchase the whole carton. We purchase small quantities, and don't get the safety apparel. I don't know of

> anyone who received them even if they purchased the entire carton. I am aware that pesticides may enter the body through respiration. We wrap our noses and faces with a cloth while spraying. However, nothing is used to protect the hands. I have experienced burning sensation in the palm. I wash my hands after spraying. I often feel nauseous and heaviness inside the head combined with burning sensation in the eyes after spraying. I haven't been seriously ill after spraying pesticides. My brother once had severe vomiting while spraying. I think now companies are employing people like you to make surveys of their product before launching them in the market. I think the idea of using protective articles is merely an advertising gimmick.

Commenting on pesticide-DSH/suicides in the community, GP, 55 years, from Maisani GP, said:

> Pesticide ingestion is a serious problem in the entire Sundarban area. My daughter-in-law committed suicide by consuming pesticide 6 years ago. One of my brother's daughters attempted twice with pesticides. Pesticide is a great danger in our homes. We cannot do without it; we have to keep pesticides for our agriculture. Farmers here are not very careful of these poisons. In a family everybody knows where the pesticides are kept. So out of anger or during a quarrel, anyone can access it easily. In the heat of the moment they ingest it and in many instances lose their lives. Pesticides are available everywhere, even a child can procure them from the village grocery shop!

Block Primary Health Centre (BPHC) DSH case register:

A DSH register (20-item DSH-Bengali Case History sheet) was designed for the BPHCs to record the socio-demographic and clinical data of self-harm cases. A medical officer in each of the 13 BPHCs was trained for this purpose. A detailed clinical interview was conducted to elicit underlying cause/triggering factors of DSH behaviour, and a psychiatric diagnosis was done using ICD 10 criteria (WHO 1994). For suicide cases, history was taken from the next of kin. There were 74 DSH cases (66–89.2% survived and 8–10.8% died) admitted to the Dwariknagar BPHC, Namkhana, in the year 2006 (1 January to 31 December).

Of the 66 individuals who attempted self-harm but survived, 43 (65.15%) were women and 23 (34.84%) were men. Attempters were predominantly Hindus (49, 74.24%). The mean age was 28.10 ± 13.32 years. Pesticide (54, 81.81%) was the most frequently used substance. Other methods included burning, hanging, ingesting indigenous poisons (Yellow Oleander–*Cascabela thevetia* and Datura *Datura stramonium* seeds).

The underlying causes and triggering factors of DSH included marital disharmony (19, 44.8%) and domestic violence (11, 25.58%), primarily pertaining to dowry-related issues. Other causes and triggering factors included financial difficulty, infertility, physical and verbal abuse, alcoholism, broken love affairs, failure in examination. Only 15 (22.72%) of the DSH cases fulfilled the ICD 10 criteria for the following psychiatric diagnoses: 6 (40%) moderate depressive episode with somatic syndrome (ICD 10 Code 132.11), 4 (26.7%) severe depression without psychotic symptoms (ICD 32.2), 2 (13.3%) mixed-anxiety disorder, 2(13.3%) Emotionally Unstable Personality Disorder.

Among the eight suicide cases, five (62.5%) were men and three (37.5%) were women. Marital discord (25%), domestic violence and dowry-related abuse (12.5% each) were reported to be the common triggering factors.

Pesticides employed included rat poison (Zinc Phosphide: $Zn3P2$) which is easily available in the market. In 8 (12.12%) of the DSH cases and one (12.5%) case of suicide, rat poison was the chosen method. The use of rat poison was noticed to be popular in the region as a method used in DSH. Companies use aggressive marketing techniques such as demonstration of the effect of rat poison on a live rat. This demonstration is seen by many villagers and helps to spread the message of its lethality across the community.

In-depth interviews with people who had committed DSH and family members:

Patients admitted to the BPHC in Namkhana between 2005 and 2006 were interviewed when stable (2–5 days after admission). Relatives of those who had committed suicide were also interviewed. Informed consent was obtained from the patient and family.

Interviews identified situational and cultural stressors associated with DSH attempts The disadvantage of female gender roles contributed to the vulnerability of women. Domestic violence and dowry-related torture were frequent themes. The following section highlights a few such narratives.

The first case named SD, 25 years, female died as a result of suicide (self-immolation). She sustained 95% burn injuries. She was Hindu by religion. It was her second marriage. Her brother gave the following narrative account:

SD had been married for one-and-a-half years. During this period, there had been few days that she was happy. SD's husband was a chronic alcoholic. Moreover, her mother-in-law did not fail to remind her every day of her one-and-a-half years of married life that her father had not kept his word: he had not paid the dowry that he had promised. This was the source of constant fights at home. SD was subjected to verbal, physical and emotional abuse along with forced starvation. SD felt very alone in her husband's house since both her husband and his mother harassed her constantly. On the day of the incident, her husband had too much to drink and was completely inebriated. He returned home in the afternoon and SD was in a foul mood as well as there was no rice. The rice he had purchased last week had finished. She reminded him that his drinking and not working was not helping matters. He slapped her. Insulted, hurt, she said she would kill herself if he did not stop hitting her. To this, the husband replied that he did not care if she lived or died. He added that if she died, there would be one less mouth to feed. Her mother-in-law supported her son. SD felt utterly traumatised and helpless. When her husband left in a huff, she went to the kitchen and doused herself with kerosene and set herself on fire.

The second case, MD, was a 19-year female. She was Hindu and had been married. She ingested Zinc Phosphide (rat poison) in the paddy field. Fortunately, she was discovered by a passer-by who took prompt action which saved her life.

The woman provided the following narrative account of why she engaged in DSH:

> I am his second wife. When I got married, I did not know that he was already married. When I discovered this, I felt very disappointed. I wondered could my parents not have not gathered more information about him before arranging the marriage? I told my husband that there could be only one woman in his life, either me or her. You see, he also provided her financial support. I had to think of my future. However, he did not pay heed. He continued his relation with her. He became physically abusive and started quarrelling with me. When I threatened to report him to the Panchayat he beat me severely and broke my nose. I had to be hospitalised. He continued his relation with the other woman. In addition, he began having an affair with another woman. I felt like garbage. I felt there was no need for me in this house apart from doing the household chores. And what do I get in return? Some food and this terrible behaviour! I thought it would be better to end my life. I went and purchased some rat poison and consumed it.

Discussion

The Lancet Global Mental Health Group (2007) in their call for scaling up mental health services state:

> We call for the global health community, governments, donors, multilateral agencies, and other mental health stakeholders, such as professional bodies and consumer groups, to scale up the coverage of services for mental disorders in all countries, but especially in low-income and middle-income countries. (p. 1241)

This is indeed a noble call. However, the study findings raise important research questions and implications for understanding Global Mental Health (GMH) global mental health:

1. How can mental health services be scaled up through a diagnosis-based protocol solely based on DSM/ICD identification? It is well recognised that DSM/ICD lenses fail to incorporate the multitude of psychosocial dimensions (e.g., marital discord and quarrel, humiliation and insult, even the emotional set-back after crop failure) which act as a proximal risk factors for DSH and even death. Where do the psychosocial dimensions of self-harm impulse fit into the diagnostic symptom criteria in those classifications? Or is there a need to think of a new dimension of distress profile rather than diagnostic criteria (Kapur 1987)?
2. What are the mechanisms, be it local, national or even international, to mitigate the billion-dollar commercial interests of the global pesticide companies? How can these be incorporated within the purview of preventive psychiatric policy? Given that all the companies are of western origin but they do business in LMICs, is there a need for international regulation particularly applicable to developing nations?
3. What are potential prevention models to address psychosocial issues, like dowry, domestic violence and gender discrimination, in LMICs? Are mental health professionals equipped to take up this task? If so, this may necessitate dramatic changes in the roles of mental health professionals to take on a social reform role and proactively engage in fighting these cultural customs in a relentless manner. This would thus be primarily a form of psychosocial intervention from the local cultural context, not a pharmacological approach. Do we have such a mental health work force to carry forward the agenda for Global Mental Health?

The present study highlights several important findings that merit attention to support efforts to reduce pesticide-related mortality and morbidity in Asian agrarian communities. These include the predominant role of pesticides in both agriculture and in DSH, farmers' unsafe pesticide practices (inadequate safety concerning pesticide practices, limited knowledge about their toxicity and inadequate precautions during storage and use, and easy access to pesticides) and the cultural practice of the dowry system and widespread domestic violence. Research has found that issues such as dowry, domestic violence and cultural beliefs and practices can lead to increased likelihood of DSH/suicidal behaviour in the region (Parkar et al. 2006) and in LMICs more generally. From a Global Mental Health perspective, it is our task to advocate inclusion and implementation of preventive measures in mental health promotion activities. Let us discuss some of these issues in more detail.

Dowry

The high degree of gender inequality, discrimination and female exploitation are among India's most serious social failures (Banerjee 2014). Dowry and domestic violence are highly prevalent 'silent crimes' in India (Bhattacharya 2004; Shrinivasan and Bedi 2007). Though in 1961 the Dowry Prohibition Act (amended in 1984 and 1986) was enacted by the Indian Government, making the practice a criminal offence, nevertheless, the practice of asking and giving dowry, dowry-related abuse and violence continue unabated and uncontrolled (Dalmia and Lawrence 2005). Dowry demands for cash, jewellery or goods can persist for many years and thus create chronic familial discord, the common manifestation being wife beating (Rao 1997). The inability of the bride's family to comply with these demands leads to the daughter-in-law being treated as an outsider, enemy and subject to varieties of abuse and torture. In extreme cases, they are simply killed (Belur et al. 2014). In the present study, six cases (9.1%) stated that dowry-related abuse was the underlying cause for their DSH. One suicide case (12.5%) by burning was dowry-related, and it remains doubtful whether this was homicide in disguise of suicide. A Panchayat member expressed:

> violence against women is fairly common. In some instances the in-laws kill the woman and present the case as suicide. The men get away either by accusing the wife of adultery or masquerading homicide as suicide in connivance with the authorities or tormenting the woman to such an extent that she is forced to commit suicide.

Dowry-related abuse and torture is often concealed, both by the woman and her parental home because of the fear of breakdown of the marriage, which is an enormous social shame. Furthermore, it is almost impossible for the abandoned girl to remarry.

Domestic Violence and DSH/Suicide

Domestic violence is a global phenomenon and is a serious global human rights and public health issue (Rose 2013). WHO's multi-country study of intimate partner violence among a sample of 24,000 women aged 14–59 years showed that a lifetime prevalence of physical or sexual violence or both, in every partnered woman, ranged from 15 to 71% (Garcia-Moreno et al. 2006). Research from the developed nations also shows domestic violence is a strong risk factor for DSH and suicide. In a review of 13 studies, Golding (1999) found suicidal tendency increases up to 77% among women who experienced violence by a partner, and the prevalence of attempted suicide is higher for women who experience both physical and sexual abuse (McFarlane et al. 2005; Wingwood et al. 2000). Studies have shown that domestic violence increases women's psychological vulnerability (Patel et al. 1999) and is associated with a range of mental disorders like depression, PTSD, suicidal ideation/attempt, substance misuse and exacerbation of psychotic symptoms (Trevillion et al. 2012). Domestic violence takes many forms like physical aggression, burns, attempted hanging, sexual abuse and rape, psychological abuse through insults, humiliation, coercion, economic or emotional threats and enforced control over speech, movement and actions. In extreme eventuality death may result (Waghamode et al. 2013; Waters 1999). It is estimated that the prevalence of domestic violence against women in Bangladesh and rural India are about 20–50% (Schuler et al. 1996; Jejeebhoy 1998). Alcohol has consistently emerged as a risk factor for partner violence (McCauley et al. 1995), as is also the harassment by in-laws for dowry in the Indian context (Kumar et al. 2005). The present BPHC data on DSH/suicide indicated that domestic violence was frequently a precipitating or triggering factor in many instances. In rural India, since most people continue to live in extended families, violence against women is perpetrated not only by the spouse but also by other members of the partner's family. Although women are guaranteed protection for certain rights under articles 14, 15 and 21 of the Indian Constitution, reflected in the Protection of Women from Domestic Violence Act, 2005, its implementation is far from satisfactory. Corruption, lack of administrative initiative, lengthy legal processes, social fear and cultural norms (i.e., the view that domestic violence is a personal matter) all contribute to thwarting the true purpose of this Act, especially in rural communities (Rao 1997).

Local Cultural Context and DSH/Suicide

There were a number of other issues which were seen as risk factors for DSH and suicide not only in the Sundarbans Region but in many LMICs. These issues include *Jhukimara*, erectile dysfunction/impotency, infertility and recurrent birth of a female child.

Jhukimara

A deliberate attempt to die, without definite desire, is locally known as *Jukhimara* or simply *Jukhi*. The literal meaning of the term is 'taking risk' (of life). In most cases the person either wants to communicate his/her sufferings as an alarm or wants to achieve something (social punishment to in-laws, diminution of parental pressure for studies etc.). Persons indulging in *Jukhimara* are often ridiculed in the community. Sometimes *Jhuki* turns fatal, primarily due to the ignorance of the lethality and amount of the pesticide consumed.

Erectile Dysfunction/Impotency

This phenomenon is noticed especially among newly married couples, when the wife complains that her husband has 'defect' (sexual impotency). The usual custom is that the GP accepts the complaint and amicably resolves the issue without taking into consideration any medico-legal opinion. Usually the husband's family is instructed to pay back at least half of the dowry and the girl is declared fit for another marriage. However, many girls have misused this situation as the Panchayat is most likely to be empathetic to the woman. To make matters worse, the local women's activist group 'Mahila Samity' takes every measure to 'save' the 'female victims' and very often victimise the men.

Infertility

Infertility is regarded as a 'female disease' and culturally females are blamed for it. Infertile women are considered to be unholy and evil and they are treated very badly, often with cruelty, by the in-laws. Infertility is considered to be a curse, and childless women are severely ostracised in the community.

They are locally called *banja* (a discourteous slang term) and are regarded as inauspicious and consequently not invited to weddings or community gatherings. Infertility is extremely stigmatising in LMICs, and on most occasions the woman has to bear the brunt of the blame, shame and guilt (Rouchou 2013). Married but childless women face physical and mental torture from both the in-laws and the husband (Bhatti 2002). Infertility is also an important cause of gender-based violence in both rural and urban India (Ardabily et al. 2011). Recent studies from Andhra Pradesh, India (Pasi et al. 2011), Iran (Daar and Merali 2002) and Turkey (Yildizhan et al. 2009) showed high prevalence of violence among married women due to infertility.

The Birth of a Female Child

The birth of female children continues to be perceived as a burden, particularly in rural India. Gender discrimination against girls often begins at birth and is widespread (Singh et al. 2009). Culturally, there is a deep-rooted preference for sons (Pande and Astone 2007) mainly because sons can inherit their father's property and land and sons are considered as a source of economic security (Hoffman 1988). The girls are considered to be a financial burden since they require dowry payment. This social attitude is the basis of gender discrimination that leads to the neglect and death of millions of girl children through lack of medical care, improper nutrition, infanticide and sex-selective abortions (Arnold et al. 2002). The mothers who gave birth to girls are also subjected to social humiliation and psychological abuse and maltreatment by their husbands and in-laws.

Prevention Strategy

In view of the enormity of morbidity and mortality related with DSH/suicide, especially with deliberate pesticide poisoning, suicide prevention should be a major focus of public health in the Sundarbans region and in similar settings (Vijayakumar 2007; Phillips 2004). Given the complexity of factors involved in suicide, it is likely that no single prevention strategy will combat this critical problem. A comprehensive and integrated joint effort involving many sectors—the individual, family, agrochemical industry, community, agricultural and health care system, media—is needed (Desapriya et al. 2004). An intersectoral global public health initiative is proposed by

Bertolote and colleagues inclusive of pesticide regulation, epidemiological surveillance, medical management of poisoning, training on safe use of pesticide and development of community educative programmes to minimise risk of intentional or unintentional pesticide poisoning (Bertolote et al. 2006). Community-based DSH/suicide prevention (Motohashi et al. 2004) is an approach being recommended by experts in the field with a detailed focus on psychosocial stressors (Phillips et al. 2002; McElroy 2004) and pesticide education programmes (Roberts et al. 2003).

Conclusion

The present chapter has highlighted the diverse psychosocial causes of self-harm in a rural agricultural community in India. In Western settings, the importance of psychiatric risk factors is highlighted in DSH and suicide studies (Cavanagh et al. 2003) whereas self-harm research in Asian countries tends to emphasise the role of sociocultural values along with emotional and situational stressors in DSH and suicide (Radhakrishnan and Andrade 2012; Phillips et al. 2002).

This study shows that DSH and suicide typically result not from a single factor but from an interaction of situational stressors and easy access to lethal pesticides. This finding has implications for policy and planning. In order to reduce premature morbidity and mortality due to DSH and suicide from intentional pesticide poisoning, all of these factors need to be addressed through an intersectoral approach involving the administration, the agricultural department, the health sector and the community at large (Konradsen et al. 2005; Mann et al. 2005; Chowdhury et al. 2007).

Administrative agencies have an important role to play in regulating and supervising the sale of pesticides, coordinating with the agricultural department in its various activities, ensuring the personnel in the agricultural department perform his/her regular duties and encouraging support to those vulnerable to suicidal behaviour.

The role of the agricultural department would include promotion of safe pesticide practice, training farmers in alternative methods of pesticide use such as Integrated Pest Management, generating awareness to purchase limited quantities of pesticide and improve storage facilities, sensitising farmers about the positive and negative impacts of pesticide use on crops, health and environment, regulating and supervising sale of pesticides in the region, and encouraging farmers to visit health centres in case of occupational exposure.

The health department should contribute to reducing the morbidity and mortality of pesticide poisoning (both accidental and intentional) by making cheap antidotes available in the community, instituting guidelines to manage self-harm patients, improving treatment, training medical and para-medical personnel, developing a regular poisoning surveillance system, and health education on poisoning among the local community members. Preventing suicide and managing suicidal behaviour also requires generating awareness among the public about mental illness and typical sociocultural contexts in which pesticides are consumed (Chowdhury and Weiss 2004).

This study also acknowledges that mental health needs include but go beyond psychiatry. In order to formulate an effective DSH and suicide prevention programme, both professional and patient perspectives should be taken into consideration (Flanagan et al. 2007). The community should strengthen family support, focusing on social justice to reduce the disadvantage of gender roles and support control of pesticides. The psychosocial dynamics leading to suicidal behaviour can be addressed by family interventions. Addressing psychosocial stressors, situational contexts and mobilising the community to assist those vulnerable to DSH and suicide constitute an important approach for reducing morbidity and mortality from self-harm.

DSH/suicide is a multifactorial problem in LMICs involving diverse sociocultural risk factors. As such, a number of important questions arise in how efforts to reduce DSH/suicide should be coordinated. For example, how should mental health specialists start to address DSH/suicide when conducting mental health clinics/services in rural communities? Can diverse social experiences relevant to DSH/suicide be included under the umbrella of mental disorders? Or might this create a dangerous predilection to ‘false positive diagnosis’ (Summerfield 2012)? Do we need new mental health constructs beyond ICD or DSM? Do psychotropic medications play any vital role in mitigating relevant psychosocial risk factors? Is the mental health workforce willing or capable enough to address the issue of DSH/suicide (keeping in mind the acute shortages of mental health specialists and professionals that can exist)? Might community psychiatry initiatives, as in India, become glaring examples of psychiatric tourism rather than genuine efforts to promote mental health (Jain and Jadhav 2009)? Can mental health professionals who have been mainly trained in western biomedical models develop enough cultural competencies (Betancourt 2003) to understand and deliver appropriate services suitable to local needs? We propose that there is need for reorganising the GMH workforce, especially in developing nations which provide a rationale for inclusion of different categories of health staff, village elders and a large number of local health care providers, including non-registered village practitioners. The concept and structure of a multidisciplinary team should be broadened to multi-group therapeutic teams. Building such a team requires extensive research and educational inputs. The WHO recommends what is termed 'gatekeeper training' in knowledge, attitude and skill development of various categories of people including spiritual and religious leaders or traditional healers for a suicide prevention programme. Inclusion of sociology and anthropology in the undergraduate/postgraduate medical curriculum would go a long way in orienting the medical fraternity about the ground reality and thereby help them in adopting a more humane approach. Similarly, imparting mental health education to students of social sciences can indeed be an innovative way of creating an additional workforce in mental health.

This area-specific study demonstrates the importance of an integrated approach for more effective DSH and suicide prevention strategies which may yield positive results and ensure a culturally sensitive GMH in India and in communities elsewhere where pesticide-related DSH and suicide is a serious public health problem.

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Mapping Difficult Terrains: The Writing of Policy on Mental Health

Alok Sarin and Sanjeev Jain

In the last few years there have been a number of efforts to both review and rephrase mental health legislation in India, and to articulate a mental health policy as a set of principles to guide thinking about both legislation and practice, as well as the role of the State in mental health care delivery. In this chapter, the authors try to explore the historical antecedents of these efforts, the ways they have evolved and the nature and scope of the most recent efforts. Recent developments in Global Mental Health have meant that mental health policies are currently being, or have recently been, written for a number of countries that previously did not have them (WHO, 2014). It may therefore be opportune to explore the Indian experience, for what lessons it might hold for others.

Mental health legislation should reflect the contemporary social situation and derive from mental health policy. The way that society views mental health and illness, and the primacy it gives to privileging individual rights (as distinct from the rights of families or care givers, or, perhaps, those of communities) needs to be considered and articulated in both legislation and policy. Paradoxically, in India, while we have had both mental health legislation

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and programmes that have been linked to plans, we have not had policy. The analogy of carts preceding horses seems apt here.

While much of this may seem painfully obvious, what is surprising is that no attempt at articulating a national policy has been made in the past. So while the country has had a National Mental Health Programme (NMHP) since 1982 (Director General of Health Services 1982) and a District Mental Health Plan since 1996 (Murthy 2011), it has had no mental health policy. This apparent confusion has been because short-term planning has perhaps had primacy over long-term vision.

In this chapter, we would like to address three issues:

- Historical antecedents to the articulation of a mental health policy,
- The possible reasons for the failures or successes of health planning, and the difficulties attendant on that assessment, and
- The modes of policy planning.

To begin with, it has often been felt that no systematic attempts at policy planning in the field of mental health have been made in India. This, however, is not strictly true.

Early Twentieth Century: Pre-Independence

For almost half a century, beginning in 1881, Indian census reports counted the numbers of mentally ill and disabled, and reviews of the data often carried suggestions for mental health services. These included suggestions for increasing the number of asylums, reducing the sale of intoxicants to ‘at-risk’ populations, as well as discussing wider issues (differences in rates of insanity by region, culture, etc.). One persistent query regarded the lower proportion of the mentally ill in India than in most other countries, often lower than the numbers of those with visual or hearing impairments. This, reviewers felt, was the obverse of most other countries, where the numbers of the mentally ill were proportionately greater than those of other categories. The census officer in 1921 provided a kind of an answer, pointing out the systematic neglect of the mentally ill by society, and the consequent appearance of low numbers. The enumeration of the disabled was discontinued from the census of 1951, soon after Independence, and may be re-introduced in the next census (Sarin and Jain 2012). The lack of this data created a blind spot that had a detrimental effect on planning for services for the mentally ill in particular.

In addition to this, specialists too had begun commenting on the need to plan for psychiatric services. Overbeck-Wright (1921) and Ewens (1908), writing in the beginning of the twentieth century, suggested extensive reform to psychiatric care. This movement gained impetus after the First World War, when changes in the UK (the setting up of the Institute of Psychiatry with a mandate for improving services in the Empire) and in India (increased involvement of Indian doctors in more 'responsible' positions) created the backdrop for improved quality of care (Mills 2006). Changes in psychiatry itself, with the advancement of both psychological theories (the popularity of psychoanalysis in Calcutta and Lahore, as also in many asylums across India) and somatic interventions (convulsive therapies, insulin coma, etc.), seemed to signal a fundamental change in treatment strategies and the hope of remission or even recovery (Ernst 2013).

In this context, Colonel Owen Berkeley-Hill, writing in the *Indian Medical Gazette* in 1923, made a plea 'for the Inception of a Mental Hygiene Movement in India', in which he asked for psychiatric care to be moved out from the confines of the mental hospitals, and for connections to be established between psychiatrists and administrators of both jails and educational establishments. He also made the economic argument by stating that the government:

> [did] not realize that one mental disorder, namely dementia praecox, probably [cost] this country more in maintaining its helpless victims for life than any other single disease.

Edward Mapother, the prominent British clinician who established the Institute of Psychiatry in London, UK, where many doctors from south Asia were trained to become specialist psychiatrists, was invited to the region to suggest methods of reform, though in a technically 'non-official' capacity. He made a number of observations and suggestions for improvements in both Ceylon and India, and discussed these in London with Moore-Taylor, the superintendent of the European Mental Hospital at Ranchi, (Jain 2003). Many of these suggestions found their way into the section on mental health services that formed a part of the Bhore Committee report (Mills and Jain 2009). The Bhore Committee, under the chairmanship of Joseph Bhore, in 1946 explored health and development, and came out with many landmark recommendations. These included a district-hospital-based kernel, along with proposals for the delivery of comprehensive healthcare services to the periphery, and a primary health care model, not merely a provision for primary care services as it was to become. As envisaged, primary health care meant the provision of clean water, vaccinations and primary prevention (which is why the Public Works Department organisation effort was to be the hub of social medicine, and could be one reason why the Health Ministry is located there). The idea was to emulate the massive improvements in health that had been achieved in the West through the employment of these strategies (Marmot et al. 2008) and to provide the essential services for first-contact help and referrals, following the General Practitioner (GP) model in the UK. K.C.K. Raja, the secretary of the Bhore Committee, reflected in a talk that the whole idea of primary prevention had been reduced, within a few years, to a 'primary [minimal] level' of medical intervention (Raja 1951).

Freedom and Efforts at Planning: Early Ideas on Mental Health Care and Hygiene

State planning for health services, as envisaged in the successive Five-Year Plans in India, has always included psychiatric services, even if, of the many suggestions, an increase in manpower has been the only one implemented, albeit very tardily. The need to train scientists and experts in all areas was keenly felt soon after Independence, both to fulfil the need of the hour (after the departure of the British experts) and to reflect the confidence of the young nation to embrace modernity. The first step in this direction was the establishing of the All India Institute of Mental Health (AIIMH) in Bangalore in 1954 to train specialists in psychiatry, psychology and psychiatric social work (under the assumption that service delivery would essentially follow the pattern in the UK and Europe). Pointedly, while the All India Institute of Medical Sciences (AIIMS), following A.V. Hill's (Hill 1945) suggestion that a medical Institute resembling the Massachusetts General Hospital be built in India, was established in Delhi at the capital, close to the seat of power, the AIIMH was established in Bangalore (erstwhile Kingdom of Mysore), which had only recently acceded to India. There was no history of medical services in native kingdoms working with the Imperial government, and the AIIMH thus represented, in a sense, a successful but 'provincial' effort at introducing psychology, social work, biophysics and Indian philosophy into mental health curricula. Postgraduate training was soon extended to other centres in India, such as the Central Institute of Psychiatry (CIP) in Ranchi (the successor to the Hospital for the European Insane, which also came under the aegis of the central government in Delhi after the transfer of power), and many general hospitals and postgraduate centres that were being established (AIIMS in New Delhi and the Post Graduate Institute of Medical Education and Research, or

PGIMER, in Chandigarh being among the early centres). AIIMH and CIP never acquired the frontline status in planning that AIIMS or other national bodies that were more directly concerned with infectious disease and mother–child welfare (the major focus in the early years) did, though they had been established almost simultaneously. The Indian Psychiatric Society, though a fledgling body, did point out the need for a more comprehensive attention to psychiatric issues, but these concerns did not result in any planned activity (De 1949a, 1949b; Bennet 1949).

Soon after this, in the year 1960, just a decade or so after Independence and during the second Five-Year Plan, the Indian National Committee for World Mental Health Year and The Indian Council for Mental Hygiene, under the stewardship of the prominent Bombay psychiatrist and later the Director of the AIIMH Keki Masani, submitted a report to the Government of India, state Governments of the Indian Union, the Health Survey and Planning Committee, and the Planning Commission of the Government of India. This is a remarkable document titled 'Urgent needs in the field of psychiatry and mental hygiene in India during the next decade along with suggestions and recommendations for meeting those needs' (The Indian National Committee for World Mental Health Year 1960). Keki Masani had trained in the UK (where he returned to practise after a few years), and had a particular interest in child development and psychotherapy. This report starts by saying that in:

> all thoughtful planning for the development of public health and medical facilities that [had] been going on in the various countries of the world, intelligent and far sighted public health planners and administrative authorities [had] been paying greater and greater attention than previously to the need for prevention of disease and promotion of positive health compared to the emphasis on curative health services, so characteristic of old time planning of more than 50 years ago. (p. 1)

This very comprehensive report, which should be a mandatory reference text for all mental health policy planners, begins with an estimation of the numbers of people with mental illness, citing the Bhore Committee report and reported prevalence rates. The report estimates that somewhere between a million and one and a half million people in 1960 would possibly have benefitted from good psychiatric care. There were perhaps 75 psychiatrists at that time in the country, with possibly 'another 75 or so, who, without being qualified in the subject, [had] acquired some slight or moderate experience of work in mental hospitals or mental hospital psychiatry'. The estimated number of mental hospital beds at this point was 15,000.

It would be appropriate to remember that this was the era before the rise of the General Hospital Psychiatry Unit (Vahia 1959; Channabasavanna 1986). At this point, training facilities in psychiatry existed at two centres: Bombay University and the AIIMH in Bangalore that granted a Diploma in Psychological Medicine. The authors suggested that, given the acute shortage of psychiatrists, which was unlikely to be corrected in the very near future, the task of mental health interventions should be shared by non-psychiatric fraternities, paying special attention to child psychiatry and social psychiatry.

To quote:

> For all these reasons, it becomes apparent that what is needed in the field of Mental Health and Mental Health services in our country during the next decade is a planned and balanced programme with the emphasis on the provision of preventive social psychiatric and mental hygiene services to as adequate an extent as possible, rather than focusing attention, as has been done, until the very recent past, and is still continuing to be done, on the curative aspects by providing a few thousand additional mental hospital beds in the country every few years. While the latter are certainly necessary, it is far more important and much wiser to train mental health personnel and establish preventive psychiatric and mental hygiene agencies and clinics. (The Indian National Committee for World Mental Health Year 1960, p.1)

The authors stress that to aid such a redirection of focus, it would be necessary to conduct epidemiological surveys to establish prevalence and patterns of ‘insanity’ and other psychiatric disorders, including behaviour and personality problems, juvenile delinquency, and psychoneurosis among children and adults. The suggestion was also made to study urban and rural populations separately, as well as to do this in different parts of the country to improve clarity.

The authors comment on the:

> effect of rapid industrialisation and technology and of the social changes rapidly taking place in the country on the lives of people and on the production of emotional insecurity, frustrations and tensions and the (subsequent) production of psychosomatic disorders, psychoneuroses and psychoses. (The Indian National Committee for World Mental Health Year 1960, p. 1)

The process of migration from rural to urban areas, the consequent stresses and the rising rates of suicide are also specifically commented upon. Interestingly, the ‘problem of indiscipline among large sections of the population’ (particularly, college students) and rising rates of physical violence are specifically mentioned, a point that current-day observers may empathise with.

The report makes specific recommendations, which are divided into mental diseases (psychoses), preventive or social psychiatry, child psychiatry and mental hygiene. Based on the suggestions of the Bhore Committee, it suggests specific improvements in mental hospital services and recommends, among other things, orientation programmes for public health doctors, nurses and community workers. It advocates psycho-education for young mothers, public mental health programmes, pilot mental health orientation programmes for rural areas and the provision of mental health services in established health centres. It specifies mental health measures in the field of education, with orientation for parents and teachers, measures to counteract prejudice, and youth counselling. It also makes special mention of the need for mental health discourse to be introduced in the services for refugee populations, and in mainstream discourse in the industry.

It also pays attention to 'Curative Service' with suggestions for in-patient and out-patient departments at teaching and general hospitals, independent community psychiatry clinics, mental hospital services and special institutions for 'mental defectives'. It talks about the need to address manpower gaps by increasing training of psychiatrists, psychiatric social workers, school counsellors and psychiatric nurses. It also refers to mental health training for medical undergraduates and other health professionals, and urges public discourse on mental health needs. It stresses the need for more mental health surveys, studies and research by multi-disciplinary scholars and researchers, actually listing out many areas of proposed study. Finally, it recommends some administrative measures that include the setting up of central and state departments of Mental Hygiene and Mental Health with an Advisor or Director to head these proposed Departments.

As a conclusion, it suggests a review of the then mental health legislation, the Indian Lunacy Act of 1912. To put this in perspective, the need to reform the law was enunciated as early as 1939, and, though mentioned in this report in 1960 by others (Nand 1962, pp. 119–121), the Mental Health Act was finally passed in 1987 (Channabasavanna 1985). A further revision, the Mental Health Care Bill of 2013, is currently under review by the Parliament (Mental Health Care Bill 2013).

As an aside, the report says that the World Federation of Mental Health, with the support of the World Health Organization (WHO), had designated the year 1960 World Mental Health Year. There is also a note that an Indian National Committee for World Mental Health Year had been formed to plan, initiate and carry out mental hygiene and psychiatric work in the country.

It talks about how an existing committee had been strengthened, and was engaged in research. The authors of this chapter, however, do not know the nature and scope of this committee.

What transpired of the work and impact of this, the Indian National Committee, in later years thus remains a subject for further exploration. Many of the suggestions articulated in it have probably found their way into subsequent proposals, and, perhaps, have even had plans based on them, but this report itself is seldom, if ever, acknowledged as the source of those ideas. What is lacking is an acknowledgement of the continuity of ideas, replaced, instead, by a sense of perpetual novelty.

What is interesting is that this document is a rather comprehensive blueprint of what a national mental health policy should look like, containing, as it does, a brief situation analysis, reflections on planning, clear and concrete suggestions for service delivery, manpower training, epidemiological research, public engagement and administrative change. It is also odd that such a detailed document was not more widely disseminated or acted upon. It is worth noting that much of what a national mental health policy should contain seems to have been made available to the State more than half a century ago.

Consolidation: 1970–1990

This brings us to more recent history. A series of early efforts in the 1970s (Kapur 1975; Wig et al. 1980; Chakraborty 1992) were translated into specific pilot programmes to inform the development of the District Mental Health Programme (DMHP). Both Kapur and Wig had trained in India and the UK, and were perhaps adapting the structure of community care as envisaged during the first wave of deinstitutionalisation in the UK to the Indian situation, with trained general practitioners and community workers as the core providers of care. Several such efforts were simultaneously developed (Chandrashekar et al. 1981), including those in Sakalvara (through the National Institute of Mental Health and Neurosciences or NIMHANS, that had formerly been the AIIMH at Bangalore, until it was made an autonomous body and renamed in 1974) and in Raipur Rani near Chandigarh (with the PGIMER), and showed that detecting severe mental illness and ensuring pharmacological treatment were possible. This was extended to a larger arena on 20 July 1985 in the Bellary District of Karnataka. Known as the 'Bellary Model' (Isaac 1988), this had a similar emphasis on 'task-shifting', where health personnel would be trained to essay varying roles and attempts were made to integrate psychiatric services with the primary health care clinics. These were noble and, indeed, valiant efforts. Counter-trends towards the marketisation and privatisation of services, the non-integration of various programmes at both the centre and state and the privatisation of medical education implied that trained manpower would not be easily available. As one critic pointed out, psychiatric care, even two decades later, continued to be under-funded, under-resourced and performing well below par (Goel 2011). Repeated efforts to highlight the extent of the problem and to make it consonant with other 'chronic disease' models have been attempted (Gururaj et al. 2005), but there has been little shared discourse between the medical and mental health care services (traced back in part to the divergent perspectives of the AIIMS and the AIIMH in the 1950s). As a result of all these initiatives, community care programmes were trialled, implemented and expanded (Chrisholm et al. 2000, pp. 581–588) as a model for south Asia and low- and middle-income countries (LMICs) in general. Led by highly trained psychiatrists and specialists in epidemiology and planning, and financed by the Government, these were only tardily incorporated into health care services. As one of the architects pointed out, despite criticisms that many of these continued to be 'top-down', culturally dissonant and driven more by WHO suggestions rather than local cultural factors (Jain and Jadhav 2008), these efforts show the involvement of experts from India with the WHO and other levels in government and non-governmental organisation (NGO) sectors, and attempted to address local needs. Whether this adequately does so is the concern expressed by others who have questioned the cultural applicability of many aspects of mental healthcare, as also the damaging effect of growing income disparities and class dynamics (an issue that seldom enters most mainstream mental health care planning) (Chakraborty 2007; Bayetti et al. 2015; Davar 2012).

It would thus seem an integral part of policy planning to evaluate the impact of earlier endeavours. That this was only sketchily done is, perhaps, where the difficulties start (Indian Council for Market Research, n.d.).

Walking Forward, While Looking Over One's Shoulder

As the authors note in an earlier work (Sarin and Jain 2013), when one tries to understand the impact of the DMHP, understanding is influenced by perspective. So, when one tries to make sense of the DMHP, different readings lead to an equally varied number of tales, each of which presents characters in a different light. In the Indian context, with its federal structure, the responsibility of the government-led health effort lies with each of the constituent states of the Indian republic, and not with the central government, as, for the purpose of administration, health services are a state subject. The process was first begun in 1870 with the Mayo Reforms, under which a fixed sum for providing civic services (which included education, jails and medical care) was the direct responsibility of the provincial administration (then the Bengal, Madras and Bombay Presidencies). Taxes and earnings were the responsibility of the central (Imperial) government. Essentially, while welfare and social services were decentralised, commercial and financial interests were highly centralised. This system has essentially been left untouched until the present.

While this decentralisation works well in theory, in practice what happens is that central programmes like the NMHP or the DMHP are funded and steered by the central ministry, which is the Ministry of Health and Family Welfare (MOHFW), and actually executed by the state ministry. The players in this rather complex scenario thus are the Health Ministry in the central government, the Health Ministry in the state government, the official machinery of the ministries and the actual people who man the DMHP sites at the district level. To further complicate matters, in some districts the DMHP is officially under the umbrella of the Directorate of Health, which runs health services, and in some places under the Directorate of Medical Education, which is responsible for the government medical colleges. It probably does not need to be said that communication between the various ministries, and indeed within various ministries, and between the two Directorates may not necessarily be of the most desirable quality. To further confound the already difficult situation is the fact that many facilities like rehabilitation centres, drug de-addiction facilities, old-age facilities and the facilities for the destitute and homeless fall under the purview not of the Ministry of Health, but of the Ministry of Social Justice and Empowerment. This seems like a holdover from Victorian periods, when poorhouses and orphanages were not, as such, the responsibility of the medical profession (or, now, the Health Ministry). Again, communication and collaboration between the two Ministries has not always been characterised by either harmony or accord.

At another level, the way that the planning for expenditure in the health sector is conceptualised, as is all other governmental spending, is in the form of the Five-Year Plans, which chart five-year courses for the Government of India to engage in development and growth. While this five-year bookending of planning may lend focus, the question as to whether this gives long-term clarity is a question that perhaps needs more debate than it has been granted.

Going a step further, planning in the DMHP space has largely been influenced by the Bellary Model project, initiated by NIMHANS, Bangalore. As has often been pointed out earlier in reviews of the DMHP, what happens on the ground is that while the ‘blueprint’ for action is the same, the ‘fidelity’ with which the blueprint is followed is extremely variable (Indian Council for Market Research, n.d.). So, while the effectiveness of the DMHP is subject to debate, even in the southern states of Karnataka, Tamil Nadu and Kerala, where it seems to work perhaps more effectively, the ‘models’ followed are very different. Kerala relies more on specialist-driven and specialist-led services, while Karnataka tries to integrate psychiatric care more into primary healthcare. In general, health intervention programmes where indices of human development are high and inequality is low have done well (e.g. in the southern states of India), while performance in other regions is inconsistent.

Many authors have commented on the possibility that while the earlier plan or policy documents were conceptually good, the problem with them has been that of implementation. Most of the plans have been conceptualised in specialist psychiatric institutions within the formal healthcare system, while the more recent ones have tended to partner with NGOs that are, in their own ways, specialists in related fields of psychiatric social work, public advocacy, health administration and so on, and are not within the administrative and regulatory ambit of the healthcare system (Eaton et al. 2011; Fairburn and Patel 2014; Gopikumar et al. 2015).

Patient or user-driven NGOs have tended to be established only in urban areas and are overwhelmingly middle class, and the needs they articulate (access to specialist care, half-way homes, financial security, legal safeguards) are seldom served by the existing service network. There is still little widespread public engagement, or civic concern, about the needs of the mentally ill, or even of their fate, as illness is most often seen as a private misfortune and not as a shared social phenomenon. There have, however, been outbursts of outrage from time to time, related to specific events such as the housing of mentally ill in jails (Dhanda 2000, p. 43), or the fire that killed mentally ill people in a religious shrine in Ervadi (Trivedi 2001), and scathing commentaries on conditions in psychiatric establishments (Nagaraja and Murthy 2008, Human Rights Watch 2014). This has, in a sense, led to planning that lives from crisis to crisis, without a larger goal either being articulated or worked towards.

Different Strokes for Different Folks

Interestingly, another aspect is the aggressive promotion of localism, which leads and encourages people to assume that they have to provide solutions within their ‘own community’ (Sébastia 2009a, 2009b; Avasthi 2010;

Andrade et al. 2014). Whether this offers a viable and acceptable model for universal application, or, in denying the notion of universality, inhibits the emergence of a wider discourse may need to be debated. The idea of a village-based, locally self-governed citizenry that has control over education, healthcare and welfare has been attempted in the 'Panchayati Raj' efforts (Singh 2008, pp. 991–1001). The Panchayati Raj is a characteristic South Asian construct, which literally means a rule of the 'Panchayat', an assembly of the 'five elders' of the village, and is a now a system of local self-governance (often with elections, to ensure local participation and control over civic affairs, at the village level). There have been criticisms of this rosy vision of village-based governance historically, as Ambedkar defined the village as a 'sink of localism, a den of ignorance, narrow-mindedness and communalism' and was glad that the State and the Constitution regarded the individual as their fundamental unit (Constituent Assembly of India Debates 1948). However, care of the ill individual continues to be the primary responsibility of the family and the local community (rather than the State), and, given societal inequality and knowledge asymmetry, it often forces the marginalised to exist in hobbled (even Hobbesian) circumstances, and they (and the communities they belong to) can then be blamed for their inability to contribute to, or even see, the 'bigger picture'.

The pitfalls in health planning have thus been obvious for quite some time. There have been attempts to decentralise services, but public control over healthcare provision has not occurred. The diffusion of the knowledge and technology of medicine is asymmetrical in many societies, but in the LMICs, this inequality is particularly stark. Thus, civic ownership, or control, over medical services is almost non-existent. Judicial intervention and media exposure have helped mobilise people to attempt to improve the situations of the mentally ill in jails and chained in temples or Muslim shrines, called *dargahs*, sometimes with tragic consequences, as when many were burnt alive when a fire started at the *dargah* in Ervadi. This mobilisation has not always resulted in a systematic improvement of the nature of care, and there have been few audits of patient satisfaction and improved services. The use of temples and *dargahs* as sites for the 'care' of the mentally ill has continued to proliferate, and studies seem to indicate that psychiatric care continues to be shared between the medical services and these. This is quite in contrast with immunisation and obstetric care, or specialist care for cardiac disease, where access to 'proper' care is a priority for health planners. It seems a widely held public belief that since the baseline was zero, the provision of any mental health service must be better than that, but over 25 years, there has been little attempt to improve the nature or quality of services.

Examination of a Work in Progress

It was in this setting that in 2011 the MOHFW of the Government of India set up a task force to develop a National Mental Health Policy (2014). Comprising 12 members from diverse backgrounds, it represented various stakeholder groups that included psychiatrists from the public and private sector, a psychiatric social work practitioner, a public health specialist, representatives of carer and user groups, NGOs and a user of the mental health system. Over the next few years, the group brought to the table for discussion their experience and world views, consulting in the process other views representative of further diversity, and visiting, in this endeavour, various sites of mental health care in the community. While a detailed record of the work of this task force is beyond the scope of this chapter, a National Mental Health Policy was prepared and finally released by the Union Minister for Health on 10 October 2014, titled 'New Pathways, New Hope'.

The formation of the task force for mental health policy and the support and encouragement that this effort has received are clearly indicative of an increased awareness and sensitivity on the part of the State towards the mental health needs of the community. It is hoped that the way in which the creation of a mental health policy may work is by the articulation of a process of thought that may serve to guide the development of service delivery. Some authors commenting on the policy, note the recognition of the need for technical support, programme management, the fostering of community engagement, stressing quality of care, improving human resources, incorporating life skills training and the extension of service to urban areas instead of the earlier focus on the rural populace (Van Ginneken et al. 2014). It remains an interesting aside that many of these aspects, though worded differently, seem to echo suggestions made in the 1960 document, referred to above, prepared by the Indian Council of Mental Hygiene.

At another level, a different aspect of the new policy document is the identification of crosscutting themes and an acknowledgement of the nexus between poverty, social deprivation, homelessness and mental illness. This recognition of the social determinants of mental health and the undeniable role that these play may lead to what remains the ultimate goal of policy: making a change in the lives of people.

The policy document, as it stands, offers some notion of a road map. It is not radical in its approach, but does emphasise the need for extensive reform of existing methods of care, and the need to encourage a more open and inclusive system of care for the mentally ill.

The Modes of Policy Planning

Given the challenges in the processes of policy planning, the obvious questions are in both the nature and location of the discourse. To begin with, should mental health planning be the domain of the expert mental health specialist? In some ways, the current effort at formulating a mental health policy has been an attempt to widen the discussion by including mental health care providers, public health specialists, and representatives of the State, civil society, family, and service users. This is perhaps the first time that such a broad-based and consultative endeavour has been embarked upon, and is, in many senses, a great step forward. The obvious question as to how inclusive that process was, and what its actual impact on the ground is, awaits answers.

Given the obvious connections between governance, implementation, inequity and socio-economic deprivation, developing the policy becomes the subject of discussion between developmental and health economists, the health administrator and mental health specialists, both those from the clinic and those working in community care. The training and expertise of these professionals in the Indian context, however, are along very different paths, and little common ground can be identified. Competing definitions of what the 'ideal' services should be get transformed into discussions about details. In a sense, the 'pilot' schemes turned out to be (individual) leader-led, with a short life after the initial interest lapsed. There was little systemic attempt to actually improve the cross-disciplinary framework to address the 'local' biopsychosocial factors that influence origins and outcomes of psychiatric conditions.

This could be one reason why the mental health plan, in all its detail, preceded the policy document. Involved with the details of the planned intervention, one could lose sight of the larger picture, and the fact that there are large issues that hinder implementation tends to get lost in a morass of detail: in other words, what the manpower should be, what the job description of each team member should be and what salary structures should be. Whether these processes are culturally or theoretically congruent, consonant with established clinical guidelines and ensure accountability and responsibility is not defined. Health care becomes something that is 'delivered' through a trickle-down of expertise, and not an expected right as a citizen.

Given these competing demands, it may almost seem that there is no possible way for change in so diverse and complicated a scenario. Since so little actually exists on the ground, any little bit is perhaps acceptable, as it would constitute a big difference. This laissez-faire approach thus becomes adequate justification for a large-scale transition, with different standards of care defined by affordability (the mental health plan is almost completely projected for the very poor—BPL [Below Poverty Line] card holders—as it is assumed that once they are 'not-poor' they will move to the private sector) and responsibility (the right to refuse treatment becomes a concern for an urban middle class, while administration of injectable drugs as part of '*Dawa* & *Dua*' [drugs and prayers] to patients housed in various temples and *dargahs* is seen as a public good). Any ideal of a uniform, standardised quality of care assurance becomes theoretically and practically non-viable.

At one level, the constitution of a task force, including both service users and caregivers, is certainly a welcome beginning. While sometimes the challenges presented by different and competing ideologies may hinder debate, negotiating these complex terrains is perhaps the only way forward. Before the present attempt at mental health policy, the onus of planning health care delivery has rather exclusively been either on the mental health specialist, or on the representative of state.

Afterword

Summarising from a historical perspective, the care of the mentally ill has been an expressed concern of various governments over the past 200 years. Under British Imperial rule, and given the nature of psychiatric care and the partial penetration of both science and medicine, efforts were focused on custodial facilities, with a belief that the community was somehow indifferent or even hostile to the marginalised. After Independence, with a gradual increase in the number of experts, facilities spread out across a range of service delivery options (general hospitals, private sector, NGOs and the few mental hospitals), and with changes in psychiatric practice, several alternatives opened up. Primary prevention and care was transformed into primary-level care, and then community-based care. The various theoretical and ideological positions that have often been portrayed as polar opposites (institution vs. community, specialist vs. task-shifting, 'Western' ideas vs. 'traditional family values') have led to a wildly swinging pendulum of services.

Thus, while the affluent could access specialists and specialised institutions, others were to be 'managed' by tertiary workers. The absence of a middle ground did not allow a healthy compromise that realistically mirrored the complex reality of mental illness. The fact that some patients could need a prolonged stay in hospitals or protected environments, or that specialist-led care in the community might be needed (or demanded) by everyone, or even that the development of a culturally congruent yet universal, secular and humanistic framework for psychotherapy was a necessary prerequisite for mental health care was not addressed. Instead, a 'one-size-fits-all' model of a brief training, a simplified algorithm for rapid diagnosis and intervention, became the mainstay of policy. This was in keeping with the larger WHO advice on the need for simple models for LMICs, keeping in mind, one assumes, their supposedly simpler psychosocial situations.

In that sense, the present policy writing process has been, at least in some ways, a departure from earlier positions both in the form of a wider participation in the process, and, hopefully, a greater breadth of vision. This has, therefore, been the first attempt at incorporating different stakeholder perspectives in policy-making, and, also, in a sense, has encouraged wider consultative participation. It can and will be debated whether 'enough' participation happened, and how inclusive that effort was. Suggesting, as it does, a greater degree of civil society oversight, and the need to look at more complex and nuanced crosscutting themes, it may encourage more effort to address these. It does need, however, to be said that earlier, fairly comprehensive articulations exist, that, perhaps, have not had enough impact. The question as to why earlier attempts have not had their desired effect remains tantalisingly poised before us. We describe several earnest and well-articulated plans for improved services for the mentally ill that have been developed over the past century. The changing focus in psychiatry itself has resulted in an almost constant shifting of goalposts of what defines adequate care: improve mental hospitals, provide care through general hospitals and address needs of those with severe mental illness as well as the 'common' mental disorders. In the Indian situation, with limited medical manpower and even less manpower in the wider mental health disciplines, such a diverse set of objectives has proved difficult to address. A level playing field as far as access to mental health care is concerned has been compromised by rapid societal changes, unequal economic and social progress, and lack of planning for universal health care. The policy document tries to address some of these concerns, with suggestions derived from a wide spectrum of society. It remains to be seen, therefore, how this policy is translated to actual change in the care of the mentally ill in the community, and this will certainly be an endeavour that has to be built upon in different ways.

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Mental Health in Primary Health Care: The Karuna Trust Experience

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Arguing that there cannot be physical health without mental health, all World Health Organization (WHO) member states in the 2013 World Health Assembly approved a comprehensive *Mental Health Action Plan 2013–2020* (WHO 2013). The plan is a commitment by all WHO member states to take specific actions to improve mental health and to contribute to the attainment of a set of global targets. Such a global commitment is in line with the comprehensive primary health care approach, which includes the provision and promotion of mental health within its ambit. It is vital that country health systems take into consideration the need to provide mental health care in an accessible manner, while taking into consideration geographical, financial and

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socio-cultural barriers to deciding to seek mental health care. The provision of good quality and accessible mental health care hence requires a functional primary health care system staffed by trained primary health care workers with appropriate referral systems in place. In such a system, specialist mental health services become only a part of the solution, wherein a responsive primary health care system addresses the majority of mental health problems. Seen in this manner, mental health care requires demystification as well as task shifting from psychiatrists in centrally located tertiary care institutions to health workers in primary and secondary care. Indeed, task shifting is a worldwide phenomenon even in countries with a relatively good numbers of psychiatrists, albeit with a young and growing evidence base (Patel 2009). For example, the UK National Health Service initiative called Improving Access to Psychological Therapies aims to provide accessible evidence-based psychological treatment for anxiety and depression through a large network of well-trained health workers in each locality functioning within a well-supervised system of mental health care (Clark et al. 2009). In the UK, the systematic progression from the publication of national-level guidelines identifying the need for evidence-based psychological therapy (as opposed to only anti-depressant medications) at the level of PHC to the funding and deployment of a cadre of therapists at local levels makes for a useful lesson in accessible and evidence-based mental health care (Layard 2006).

In this chapter, we briefly discuss the large unmet need for mental health care in several low- and middle-income countries (LMICs) including India. With this background, we present our experience with integrating mental health services into the primary health care system in one of the districts in the south Indian state of Karnataka. We describe the history of a programme initiated by R. Srinivasa Murthy and K.V. Kishore Kumar of the National Institute of Mental Health and Neurosciences, Bangalore (NIMHANS) in 1995. Both of them were psychiatrists (then at NIMHANS), and have worked closely with non-governmental organisations (NGOs), doctors in primary health care and community health workers to develop decentralised mental health care. The need to develop such a programme was identified by them in order to understand the mental health needs of a tribal and rural population, and explore the feasibility of working with primary health care workers. We illustrate some of the lessons learned using two brief interview-based case studies, and discuss the limitations and challenges of this experience. We hope that such experiences can shape a systemic response by governments and policymakers to make mental health care accessible through the wide network of primary health centres (PHCs).

Use of Non-professionals for Mental Health Care

During the 1960s and 1970s a trend emerged of involving non-professionals for delivering mental health care, known as 'de-professionalisation'. Non-professional workers are often able to provide accessible and patient-centred care because they have better knowledge of the community, language and customs. Patients may also readily identify with them and form therapeutic alliances. However, it is important to ensure that non-professional workers are competent, and that professional staff can be drawn upon, when necessary, to deal with complex cases, provide supervision and consultation-liaison. If non-professional staff are to be trained and employed, consultation with professional staff is needed to avoid the perception that non-professional staff are undermining professional staff, lowering standards of care, and providing service managers with a less costly workforce (WHO 2005).

However, the WHO Mental Health Atlas 2011 points to glaring disparities in the distribution and availability of mental health care across the world (WHO 2011). In many LMICs, there are severe inadequacies in the care provided as well as an inequitable distribution of health workers trained to deliver mental health care, be it psychiatrists or primary care workers who can identify and manage mental health problems in the community or in primary care settings. WHO estimates that nearly half of the world's population live in countries where there is less than one psychiatrist for 200,000 individuals (WHO 2011). In many LMICs, a legislative framework is the first step towards organising and delivering mental health care; only 36% of low-income countries are covered by mental health legislation (WHO Secretariat 2011). There is also a disparity in the type of facilities available for treatment. Sixty-three per cent of inpatient facilities for the mentally ill in LMICs are located in dedicated mental health care institutions with poor linkages to the other health services and systems. At the community level, most LMICs have limited availability of mental health services. Even at primary health centres and secondary hospitals, health workers are not trained to identify, manage or appropriately refer people with mental health care needs. In terms of proportion of country health expenditure on mental health, it is estimated that 67% of health budgets are being spent on tertiary level care in specialist mental health care institutions (WHO 2011).

Over the last several decades, globally, mental health has gradually shifted from being centred on specialist psychiatric hospitals to primary care institutions (WHO 1975). Such a move relies on various underlying principles ranging from cost-effectiveness and economic arguments to the integration of health and human rights, comprehensive primary health care perspectives and increasing access to care. The push towards *communitisation* (shift of care to the community from specialised institutions) of mental health and grounding it within general health services as well as pushing for greater civil society and community engagement with mental health care is a part of a global trend.

There are many reasons for this integration of mental health with primary health care. Firstly, the widespread reporting of the unaddressed burden of mental health problems in primary health care outpatient settings; secondly, the limited number of psychiatrists and other mental health professionals to provide specialised psychiatric care; and thirdly, the emerging global trend towards integration of all health programmes from a vertical disease-control programme model to a multipurpose and integrated model. Fourthly, there has been a growing international recognition of primary health care as the approach to organise accessible health services. Fifthly, there has emerged a global movement towards strengthening health systems to deal with chronic conditions and a push to early detection wherever possible to prevent chronicity. The latter has guided the global recognition of the concepts of continuity of care and community-based care that are today being embraced as important characteristics for local health systems in order to deal with the challenges of all chronic health problems ranging from tuberculosis and HIV/AIDS to diabetes, hypertension and other cardiovascular conditions. Consequently, integration of mental health into PHC requires systematic capacity building at primary health care level, development of simple interventions, as well as setting up appropriate support mechanisms through referral pathways and feedback systems to ensure that primary care staff feel adequately supported to provide mental health care (WHO & World Organization of Family Doctors 2008).

Mental Health Care in India

In India, the journey of mental health care has a long history, ranging from descriptions of mental health problems in ancient Ayurveda texts to contemporary post-independence efforts at establishing a system of care for mental health through policies and programmes (Agarwal et al. 2004; Nizamie and Goyal 2010). Despite a long history of written discussions of mental health, a comprehensive historical and analytical review of mental health initiatives by Murthy (2011) reports that at the time of independence, mental health was not considered as part of the general health services but to be delivered by mental hospitals following the establishment of *asylums* under British colonial rule (Murthy 2011). There was a severe dearth of infrastructure for providing mental health care services with as few as one bed per 30,000 people in India at the time (Murthy 2011). The initial two decades after independence were dedicated to significantly increasing the number of beds in mental hospitals and humanising treatment of the mentally ill. The mental hospital beds increased from 10,000 to 20,000 in the first decade after independence. In the 1950s, families in India were involved as part of the treatment process, at a time when institutions in high-income settings routinely separated patients from their families for treatment, seeing the family as contributing to pathology rather than co-opting them into organising care. Introducing psychiatric wards in general hospitals then followed in the 1960s in a significant way. In 1975 for the first time mental health was integrated into general health services under the banner of a community psychiatry initiative echoing a global trend—backed by the WHO—towards de-institutionalising mental health care and introducing community mental health (Agarwal et al. 2004; Anthony 1993). In India, the community psychiatry initiative has been active in 127 of the 626 districts, catering to about 20% of the population (Murthy 2011).

Challenges of Mental Health Care in India

Large ‘unmet need’ for mental health in the community

- Lack of awareness that psychological distress requires medical intervention in the general population
- Limited acceptance of modern medical care for mental disorders among the general population
- Limitations in the availability of mental health services (professionals and facilities) in the public health services
- Difficulty in uptake of available services by the mentally ill
- Lack of integration of services in recovery and reintegration of persons with mental illnesses among various actors
- Lack of institutionalized mechanisms for organization of mental health care.

From Murthy (2011), National Medical Journal of India

In some respects, India's early efforts in mental health are laudable. In 1982, when the National Mental Health Program (NMHP) was launched, India was one of the first post-colonial countries to have a mental health programme (van Ginneken et al. 2014). There have been several initiatives in the last few decades focusing on outreach services in rural areas, as well as providing community-based mental health care in such areas to supplement the tertiary institutes of mental health. There have also been initiatives focusing on rehabilitation and health promotion (developing appropriate awareness-raising material, improving the community's understanding of mental illness, extended care for caregivers of mentally ill individuals etc.) (Patel and Thara 2003).

However, many challenges persist in achieving a reasonable standard of mental health care in India including poor systematic evaluation of small successes in micro-contexts, poor training capacity, socio-cultural mismatch between programme design and services, a grossly under-financed health system and poor agenda-setting, political will and leadership at various levels (Jacob 2011; Jain and Jadhav 2008; van Ginneken et al. 2014).

Photo 1 An elderly person waits for the doctor at a rural primary health centre in Karnataka, India. Many such centres are not yet equipped to cater to the large unmet mental health care needs of rural populations

Integrating Mental Health into Primary Health Care

By definition, comprehensive primary health care includes curative and preventive care, mental health promotion and psychosocial rehabilitative components of mental health care (Magnussen et al. 2004). In several LMICs, non-specialist health workers are deployed in primary health care settings (including doctors, pharmacists, laboratory technicians, nurses and other health workers, none of whom are specialised in mental health). Management and delivery of a variety of pharmacological and other interventions for mental, neurological and substance abuse disorders has been demonstrated in a variety of community and primary health care settings across the country through systematic capacity building and supportive supervision (Agarwal et al. 2004).

Mental health care in primary care is a logical way forward to address the mental health needs of the population, taking into consideration the resources for mental health available in the country. In a mixed public and private health provider landscape in India, the growth of psychiatry in the private sector has also progressed, albeit catering mainly to the urban population. In most rural areas, large gaps exist in terms of sheer availability of psychiatrists, counsellors and health workers with knowledge and/or skills for providing mental health care. There is a 40–60-fold deficit in the number of clinical psychologists, social workers and nurses (van Ginneken et al. 2014). As for primary mental health care, the District Mental Health Programme (DMHP) is in place in some districts only. DMHP is conceived as a community-based mental health service delivery programme initiated through early pilots in the 1980s and later in 1996 institutionalised under the NMHP and is being extended in a phased manner (Agarwal et al. 2004; Jain and Jadhav 2009). DMHP now operates in 189 out of 652 districts of India. In India currently, there are 43 mental hospitals and 10 centres of excellence in 652 districts altogether generating 30,000 inpatient beds. In addition, mental health services offered at government medical colleges were upgraded in terms of provision of mental health services, and also to increase the number of post-graduate training programmes for doctors (Sinha and Kaur 2011). Nearly all of the psychiatric inpatient beds are in large urban and peri-urban centres, hundreds of kilometres away from most of the rural Indian population. This resource is grossly inadequate in comparison to the need. The scaling up of these systems involves building a comprehensive mental health care service by developing partnerships with the primary health care teams, community-based organisations, NGOs, service users, family groups and various government departments. However, the availability and treatment of mental health problems in primary care is still not effective. Unfortunately, initiatives targeting mental health, including the DMHP, are specialist driven, and located in the *talukas* or above. *Talukas* are administrative sub-divisions of districts (also called blocks in some states of India). The headquarters of the *taluka* is usually a large town. *Talukas* usually have a population ranging from 100,000 to 400,000 people, and are thus not the ideal location for providing primary mental health care, leaving mental health care inaccessible to a very large rural population.[1]

In Karnataka and possibly in most other Indian states, PHCs have limited capacity to identify or treat mental illness. In 2011, an evaluation across 24 PHCs across Karnataka found that most PHCs see very small numbers of mentally ill people. Many of the PHCs surveyed across Karnataka were seeing 10% or less of the expected number of mentally ill in their catchment area (Prashanth et al. 2011). The PHCs surveyed were involved in a project on integrating mental health care into general health services. Although mental health training has been conducted for several primary health care doctors of Karnataka by NIMHANS, health worker training on mental health in primary health care is not yet routinely organised. The survey found that posters and awareness generation materials and manuals in English and Kannada[2] were available at these PHCs. A questionnaire on the knowledge, attitudes and practices of primary health care workers on mental illness found that their awareness levels were fair, although the assessment was done after a recent training programme. The maintenance of case records of patients seen at PHCs was below average and follow-up of registered cases was also delayed. A robust system of registration and follow-up is crucial to delivering mental health care at PHCs. There was a clear dearth of clinical skills among the doctors. Most doctors were not comfortable working with mentally ill patients or were not used to counselling. Moreover, many doctors trained under the Indian systems of medicine, who are routinely posted in many PHCs in India showed a significant knowledge gap in identifying mental health problems.

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[1] Various critiques of the DMHP including several ethnographic approaches at understanding its local effects as well as macro national-level critiques have emerged in the recent years. While some have praised the underlying principles of the DMHP, a lot has been written about its patchy implementation and its dependence on a very weak and under-financed health service, poor leadership and political will and its specialist-driven character. See, for example, Badami (2014) for a particular case of DMHP's limitations in mitigating suicide incidence in the *Paniya* community in Kerala or the need to reconcile possible multiple narratives about the DMHP by Sarin and Jain (2013). For an ethnographic study that discusses the specialist-driven nature of DMHP, see Jain and Jadhav (2009).

[2] Kannada is the local language in the south Indian state of Karnataka.

One of the early experiences at integrating mental health into general health services in Karnataka was by several actors coming together at the Gumballi PHC run by Karuna Trust in the year 1996. Karuna Trust is a NGO that is involved with strengthening primary health care through innovative projects implemented in PHCs that they run in partnership with the government. Karuna Trust (founded in 1986) and its sister organisation Vivekananada Girijana Kalyana Kendra (VGKK), founded in 1981 by Hanumappa Sudarshan, have been recognised for their integrated approach to addressing development issues of indigenous tribal and rural communities in India. The Trust raises resources for its activities mainly from the government but also from various other philanthropic organisations, individuals and funding agencies. In a brief case study below, we describe the nature of activities related to integration of mental health services into primary care in Gumballi PHC, and list various lessons learned and challenges that remain. The Gumballi PHC located in Chamarajanagar district was the first PHC in the state to be handed over to the Karuna Trust under a public–private partnership initiative of the Karnataka Government in 1996. The PHC continues to function within the larger district and state health system, but the daily operations and management are by Karuna Trust. The Gumballi PHC is one of the 2355 PHCs in Karnataka, located in Chamarajanagar district in the southern part of Karnataka. The district is one of the more worse-off districts in terms of various social and development indicators including health, education and socio-economic development (Government of Karnataka 2004, 2005).

Gumballi PHC: A Case for Non-specialist-led Mental Health Care

The Gumballi PHC, although one of the pioneers in initiating mental health within a primary health care setting, is not the first such experience. Early efforts at integrating mental health into primary health care began as small pilot rural mental health programmes in the mid-1970s in Bangalore in southern India and in Chandigarh in north India (Murthy 2010). The programme in Bangalore was led by the community psychiatry department of NIMHANS, a national-level expert centre for psychiatry. The aim of the project was to develop suitable training programmes for the doctors and multipurpose workers from various PHCs in Karnataka so that after their training primary health care personnel could provide basic mental health care (detection and management of epilepsy, neurotic illnesses and psychosis). The team studied the needs of rural population, followed by a pilot project to integrate mental health with primary health care in a PHC serving a population of 100,000 in the early 1980s. Similarly, the Chandigarh project focused on developing a model for rural psychiatry services with the support of WHO. Subsequently, these projects led to various PHC-level pilot initiatives in and around Bangalore as well as the early district-level pilots in Bellary district in northern Karnataka. A detailed history of the evolution of early pilots in Bangalore and Chandigarh in the 1970s, their subsequent transformation into district-level initiatives such as the DMHP in the 1980s, and the few evaluations of these programmes is provided by Murthy (2010).

The integration of mental health into primary health care at Gumballi PHC is one of the spin-offs of the DMHP and other community mental health initiatives of NIMHANS, Bangalore, in partnership with Karuna Trust. The Gumballi PHC intervention can be divided into three phases. The first phase involved understanding the needs of the population and exploring the feasibility of providing mental healthcare. The second phase was the pilot involvement of the health workers in mental health care. In the final third phase, Karuna Trust tried to extend the care to other PHCs using training programmes, tele-psychiatry and other innovations. The aim of the Gumballi PHC mental health initiative was to train health workers, auxiliary nurse-midwives (ANM) and doctors in PHCs to integrate mental health into general health care. The ANM is a community-based health worker attached to a sub-centre. Sub-centres are the first point of contact between the government health services and the community in India, and currently focus on providing reproductive and child health services. However, the ANM is also the first point of contact for various other disease-control programmes and initiatives including follow-up and referral services for the mentally ill. As part of this activity, all male health workers and ANMs, doctors and community-based social workers associated with the Karuna Trust were trained, and monthly mental health outpatient clinics were organised at the Gumballi PHC on every second Saturday. The training involved classroom training on sensitisation to mental health problems seen in the community, building a referral pathway to the PHC, and skills for listening and engaging with family members and mentally ill patients. The classroom training was reinforced through on-the-job training and supervision by visiting psychiatrists and the medical officer of the PHC. The on-the-job training involved a process of continuous improvement wherein the case management of every patient seen was discussed. During each subsequent consultation, the health worker was involved in the consultation, follow-up and discussions on the patient's response to treatment.

In the first phase, the programme started with the training of the health workers and village visits within the Gumballi PHC catchment area and around. The health workers administered a 10-point questionnaire in village meetings and focus groups to help improve awareness and detect people with mental illness within the community. During this process, the community's dependence on faith healers for seeking care for mental illness emerged and a conscious effort was made at contacting and building a rapport with these healers. Karuna Trust's earlier demographic work with leprosy, experience with community-based tuberculosis care and especially its work on community-based management of epilepsy initiated in the early 1990s was helpful in providing an impetus to the community-based mental health care work. During this early phase, the programme worked with traditional healers and faith healers from the community to sensitise them about various mental health problems. Over a period of time, the traditional healers and faith healers began to refer people with severe mental illnesses.

The most common problem encountered in the clinics initially was patients with severe mental illnesses who presented long duration of illness. Gradually, patients with shorter duration of illness started utilising the services, indicating patients who began to seek treatment earlier. On average, about 50–60 old patients and 5–10 new patients were seen each month every second Saturday. The patients who came to the clinic were offered a clear case management plan with strategies to educate the families about the nature of the illness, need for medication, side effects that may occur, need to initiate home-based vocational activities, dealing with specific problems like social rejection and crisis intervention (as and when necessary), as well as free medication. For nearly a decade since the establishment of the clinic, K.V. Kishore Kumar, a psychiatrist from NIMHANS, visited the facility every month. The long-term plan was to slowly shift various diagnostic, treatment and follow-up tasks to the local staff through a systematic process of capacity building and reflective discussions at the end of the clinic.

After seeing the patients, health workers, nurses, pharmacists and doctors were involved in discussing the problems seen on the clinic day. In addition to the systematic training provided to the health workers in the classroom, these post-clinic discussions and debriefing sessions served as useful platforms to build the skills for history taking, diagnosis and patient communication. At the end of the clinic day each month, an assessment was also made of those patients who did not turn up for the monthly follow-up visits that day. The community-based health workers and the ANMs were supposed to visit these families in the following days and report about their progress to the doctor in the subsequent visit. In case the patient was found to be very ill, or they had problems in attending the clinic, appropriate help was provided in keeping with the need. Those patients who were very ill were referred to the VGKK tribal hospital in BR Hills (in the same district) for inpatient care, since the nearest inpatient care for these problems was only available in Mysore (80km by road) or Bangalore (180km by road). They run a hospital for indigenous tribal communities, a school and a vocational training centre at BR Hills in Chamarajanagar district. Over a ten-year period, more than 80 patients were admitted to the VGKK hospital in BR Hills for inpatient care, and discharged to be followed up by the community-level workers associated with the programme.

Most PHCs in India do not maintain medical records. Recently, there have been a number of pilot projects for maintaining immunisation and health records, but ensuring continuity of care for chronic diseases remains a challenge in most settings. In 1996, when the Gumballi mental health clinic started, registration of all patients and provision of PHC-based health records was prioritised in order to ensure continuity of care, a defining component of mental health care. All people with mental health problems who registered in this clinic had a file, which consisted of data on background characteristics, clinical variables and qualitative information about the family, occupational functioning and difficulties experienced by the individual. Over 2500 patients with a nearly equal representation of both genders were registered in this clinic over a period of 14 years.

Even though Chamarajanagar district was one of the DMHP implementation districts, for a large part of its existence, the programme remained on paper only. The growing popularity of the Gumballi clinic attracted a lot of mentally ill patients, not only across the district but also from neighbouring *talukas* of adjoining districts. Eighty-seven per cent of the 2648 patients seen were in fact outside the catchment area of the Gumballi PHC, indicating the severity of mental health care needs in the other primary health care areas of the district. Also, being housed within a PHC was very important as it catered to the most socially vulnerable groups with mental health care needs—85% of patients seen till 2009 were from households below the poverty line and 43% of the patients were from scheduled caste/scheduled tribe communities.[3] Over half of the patients seen (50.3%) were illiterate. Many of these categories of patients may not be able to seek care in distant cities or in for-profit private facilities. Below, we present two case studies prepared from interviews with a health worker and a patient who volunteered to share her experience with the clinic. Subsequently, we summarise the lessons learned in integrating mental health care into PHCs organised according to their relevance to diagnosis, treatment, follow-up, rehabilitation, co-morbidities and the impact.

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[3] The Indian Constitution identifies several socially disadvantaged population groups as scheduled caste and scheduled tribe for various types of affirmative action. These population groups are among those facing varying degrees of social disadvantage and exclusion and various schemes and programmes of the government target these groups.

Photo 2 Gumballi PHC maintains medical records of all patients seen in the programme

Photo 3 The clinic continues every second Saturday. It is managed by a PHC doctor trained and supervised in providing basic mental health care

Case Study 1: PHC Workers Can Play a Major Role in Providing Mental Health Care

Mahadeva Murthy grew up in Komaranapura, one of the sub-centres within the area covered by the Gumballi PHC. His father worked for daily wages and often was not able to find work every day. With six children to feed and raise and with no land of his own in a largely agrarian part of Karnataka, Murthy's father's struggled to make ends meet. After a degree in arts in the early 1980s, there was a lot of pressure on Murthy to not continue with his studies, but contribute to the family's meagre income. Introduced to Karuna Trust by a social worker, he was initially involved in their community-based leprosy elimination programme. He participated in door-to-door surveys, conducting community awareness generation meetings and using flip-charts, posters and awareness generation materials. Subsequently, as Karuna Trust expanded its activities to tuberculosis, he also began to participate in that programme. When the NIMHANS team and the medical officer at VGKK hospital were looking for health workers who could join their effort at detecting mental illnesses in the community, increase awareness on treatment of mental illnesses and refer such patients to the PHC, Murthy (among several other such non-professional health workers) was a natural choice. He attended a ten-day training at NIMHANS where he participated in lectures, watched patient education material and was shown several signs and symptoms of mental illnesses by the psychiatrists there. Subsequently, under the supervision of the medical officer at VGKK hospital, Murthy and several other health workers like him improved their listening skills and were able to help people in the community identify mental illnesses and take them to the PHC clinic for treatment. At the clinic, Murthy would talk to all the patients, make notes about the improvement/deterioration of various symptoms, chat with patient's family members about their attitudes towards care for mentally ill, assess compliance to treatment and organise appointments for home visits and follow-up visits in cases where the medical officer identified such a need. Under the supervision provided by the psychiatrist (initially) and later taken over by the local doctor, Murthy today feels confident of being able to help people with mental illnesses. He looks back at his stint in various disease-control programmes including leprosy, tuberculosis, epilepsy and mental health and observes that mental health is the only one which really helped him form lasting relationships with patients and helped him improve his communication skills in general. He feels a sense of purpose today and is very satisfied with his decades of work in mental health. Not much has changed in terms of referral and availability of mental health care in most of the government PHCs, he notes as he has a lot of experience with patients from neighbouring PHC areas who were referred to their own PHCs for medicines returning to Gumballi citing non-availability of these medicines and/or erratic supply. He also laments on the lack of a programme for mental health such as the ones for tuberculosis and leprosy, attributing the decrease in the prevalence of these diseases to the existence of national programmes specifically providing health workers for these purposes at PHCs.

Photo 4 Mahadeva Murthy

Case Study 2: Huge Unmet Need for Mental Health Care in Rural India

Indira (name changed) is today in her late 30s. In her late teens, her aunt and parents noticed a distinct change in her behaviour. She began to talk a lot and easily picked fights with people at home. She would sometimes suddenly break into song and dance. Initially, these symptoms would eventually decrease in a matter of weeks. For some years, the family members attributed this to her age and growing up. When this became more severe, they were confused as to what to do. In 1997, one of her parents' neighbours informed her aunt that there is a visiting doctor from NIMHANS, Bangalore, who comes to a government PHC eight kilometres from their village. The aunt shared that, in their village (which was within the area covered by Gumballi PHC), health workers had visited home to home inquiring if there were people in their village with some of the symptoms that Indira had. She also informed Indira's aunt that these were treatable with medicines and counselling at the PHC. Ever since that visit to Gumballi PHC in 1997, Indira has been on treatment with medicines for bipolar affective disorder and attends monthly follow-up visits. She notes that in 2007 the doctor informed her that the government is now extending the mental health programme to all PHCs and the Gumballi doctor referred her to continue further treatment at a PHC in her own village. She describes this as a difficult experience. She notes:

> Our PHC is nearby but for my kind of problems, they don't keep medicines. They did give me CPZ tablets [chlorpromazine, an anti-psychotic medication] for some weeks, but the supply was so erratic. They also don't have a system of writing in records or helping me with my problems. Finally, I decided to go back to Gumballi itself.

She is glad that she is able to discuss her problems on a monthly basis with a doctor and obtain medicines every month. Indira's family, over time, has understood her needs and takes care of her. She takes care of a lot of household chores and lives most of the time with her sister's family. Indira was born into a family recognised as a scheduled caste. After several years of facing structural discrimination and being socially disadvantaged, scheduled caste and scheduled tribes are recognised by several affirmative action policies. Indira's family is somewhat atypical in being economically better off than most of the scheduled caste families. Her family also supports her with a moderate monthly allowance and takes care of her cost of medicines (already subsidised at Gumballi PHC). She accompanies them to family events and gatherings. Today, Indira appears confident that she will overcome occasional episodes of increased anxiety and suspicion with the support of family members and continuing treatment at the nearby Gumballi PHC.

Photo 5 Indira

Lessons Learned

Below, we have summarised the lessons learned in integrating mental health care into PHCs organised according to their relevance to diagnosis, treatment, follow-up, rehabilitation, co-morbidities and the impact.

1. Diagnosis

    (a) The administration of a screening tool in the form of a questionnaire, administered systematically at the village level (in focus groups with village heads and self-help groups) to identify people with mental illnesses was very useful in improving awareness on identifying mental health problems in the community as well as extending care to the *invisible* mentally ill.

(b) Initially, patients often presented to the clinic several years after onset of the illness. This trend slowly shifted to patients with recent onset of symptoms visiting the clinic. Patients with depression often presenting with multiple somatic symptoms were diagnosed and initiated on treatment. As the programme progressed, we began receiving referrals from community members, often households or neighbours who could identify patients with symptoms of mental illness and refer them to the monthly clinic.

2. Treatment

(a) Most of the patients with psychosis received only conventional neuroleptics like Fluphenazine and Chlorpromazine as they worked out to be more economical. Yet, it was found that they were very effective and safe without many side effects at the doses in which they were used. Atypical antipsychotics were used only in exceptional cases.

(b) Registration at the clinic entitled patients to routine follow-up, monthly medication and health worker visits to homes wherever necessary. Good quality generic medicines were procured in bulk and were given at cost price to patients. Average cost of treatment (including registration, consultation and medicines) for a typical patient undergoing treatment with antipsychotic medication was less than $5 per month (about INR 200 per month). During the last few years, the Karnataka government improved the availability of free medicines for mental health problems in primary care and even this component of the cost was therefore removed.

(c) Lithium, as a mood stabilising agent, was used in people with bipolar affective disorders. This was followed even though there was no facility to check blood levels and patients, though advised, would often not be able to afford monitoring lithium levels at laboratories located in faraway cities. It was always used at lower doses than that used in tertiary mental health establishments and again it was found that it was effective without side effects in the doses in which it was used.

(d) Such experiences gave us the confidence to use them in cost-constraint situations with good success. Based on the Gumballi experience, it was possible to help various other community-based mental health initiatives in costing medicines and care.[4]

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[4] The second author V.S. Sridharan was an external evaluator for a few community-based mental health initiatives across the country. He could share his insights with these projects based on his experience in

   (e) The project focused on treatment of severe mental illnesses such as major affective disorders and psychosis. In view of the nature of staff involved and their training, there was a relative neglect of psychosocial interventions to supplement the medicines. Also, the clinic did not explicitly focus on substance abuse or alcohol addiction, although patients with these problems also began to present themselves at the clinic over the years.

3. Follow-up

   (a) It was found that some patients could not come to the clinic for follow-up due to practical difficulties like bringing an acutely psychotic patient by public transport, an elderly caregiver and economic difficulties. The clinic team led by the doctor and sometimes the visiting psychiatrist visited the house of the patient on a regular basis to provide treatment. Such involvement and sustained effort from the clinic and the positive outcome it brought out reinforced the faith of the community in treatment.
   (b) Some very severe cases, which could not be managed at the clinic, were even referred or even transported to NIMHANS for further management.

4. Rehabilitation efforts

   (a) Rehabilitation was the most challenging component of the care provided even though it is an integral part of mental health care. Community-based rehabilitation requires convergence and intersectoral coordination between a variety of actors at the village, *taluka* and district level. In a limited way, rehabilitation opportunities were explored and provided for some patients within Karuna Trust.
   (b) Families were helped and empowered in getting linkages with existing social welfare schemes of the government to mitigate distress secondary to dysfunction in the individual leading to economic difficulties. Although the schemes are limited in their scope and difficult to access

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anchoring the mental health programme at Gumballi. The projects that benefited from these insights include Association for Health and Welfare in the Nilgiris (ASHWINI), Tamil Nadu, The Banyan, a voluntary organization working for homeless mentally ill women in Chennai as well as its initiative for the Tsunami-affected community in costal Tamil Nadu, Paripurnata, a voluntary organization established in the year 1991 with the vision of bringing hope and wholeness in the lives of mentally ill women, and The Richmond Fellowship Society (India) Bangalore which has developed a community-care model in rural Karnataka.

for the most affected and vulnerable, they are often the only available source of support for many families that are severely affected socio-economically by a member suffering from mental illness.

(c) Volunteers were identified in some of the villages in the catchment area and trained to support the families caring for persons with severe mental health problems. They often discussed with the health worker many issues like discontinuation of medication, not keeping follow-up contacts, specific difficulties encountered by the families and crisis situations. Many of the volunteers advocated for employment for the affected person in the village or with any other potential employers in the neighbourhood.

(d) Support groups of people and families with mental illness were also initiated to share their experiences every month. This activity typically lasted for about 45 minutes before the consultation or reviews occurred.

5. Co-morbidities

   (a) Co-morbidities like tuberculosis, severe anaemia requiring blood transfusion, diabetes mellitus and hypertension were also addressed when identified. This was especially possible because the clinic was housed within a primary healthcare facility.
   (b) Through their participation in a primary care facility that provides mental health care, over time, caregivers' attitudes towards addressing mental health components of other diseases also improved. There is anecdotal evidence to suggest that patient-centered care provided by doctors and health workers participating in the clinic improved due to their becoming sensitive to mental health care needs of patients.

6. Impact in the community

   (a) Over time, the community developed an insight into the treatable nature of mental illnesses and it gave a new hope and help to the silently suffering family.
   (b) Many opinion leaders and people of prominence in villages and towns began to talk openly about seeking care for mental illnesses at the health centre and this helped address social barriers to seeking care for mental health problems.
   (c) Though we could not document evidence of reduction in deliberate self-harm in the mentally ill, the availability of care at the level of primary care contributes to decreasing such instances. The availability

and responsiveness of PHC staff to mental health emergencies and follow-up visits improved the confidence among patients and family members.

7. Other impacts

    (a) The PHC health workers were trained and sensitised to identify different types of mental illnesses like schizophrenia, depression and bipolar affective disorders. We found that this skill was dependent on observation, careful history taking and patient communication and was often neglected in medical training and lacking among professionals in several other primary health centres.
    (b) Involvement in caring for the mentally ill also enriched the soft skills of the medical and para-medical staff to address other programmes for chronic diseases like diabetes, hypertension, epilepsy and tuberculosis.
    (c) The experience also made us aware of the need for and feasibility of running an alcohol de-addiction programme at the community level.

As there are only about 3500 psychiatrists for over a billion people in India, they are better involved as trainers and not as the primary caregiver for the mentally ill. However, the presence of strong alliances between psychiatrists and PHC teams in the form of formal referral networks or through strategic linkages with NGOs and private practitioners is needed. The role of psychiatrist in providing a higher level of care as well as providing expert input on treatment plans for existing patients is crucial to the success of an integrated PHC-level mental health care programme. The psychiatrist may review the programme periodically and give on-site training and plan psychosocial rehabilitation facilities within local settings.

As the programme evolved, and access to mental health services increased in the local area, patients who were using the Gumballi services were subsequently referred to facilities closer to where they lived. Today, the availability of medicines in several PHCs across the state has improved and whenever possible patients are referred for care to their respective PHCs. Although there are still many challenges in the scale of human resources and capacity gaps for delivering mental healthcare in PHCs in Karnataka, there is no doubt that it is possible to do this cost-effectively when there is a local vision to provide mental health care within PHCs, a committed team led by a doctor as well as key linkages with tertiary mental health care facilities (medical colleges or specialty hospitals with psychiatry departments).

Broadly, the lessons learned may be summarised as follows:

1. There is a wide range of unmet mental health care needs in the community, especially in the rural areas of India. The challenge of reaching services is accessibility, acceptability of the offered services and the affordability of care.
2. It was possible to provide inclusive mental health care within primary care settings in a relatively deprived and largely rural south Indian district.
3. A large number of people benefitted from decentralised mental health care, which was a specialist-assisted, but eventually non-specialist-driven programme.
4. Our intervention increased the number of people who sought medical treatment for mental illness in addition to traditional healers and faith healers over a period of time, as evidenced by the fact that number of registrations for acute psychosis increased in the clinics. In view of early involvement and negotiations with these actors, it was also possible to establish an informal referral system from traditional providers to mental health services, especially for severe mental illnesses.
5. People and their families exhibited a great degree of comfort using these services.
6. It was gratifying to note that non-specialist primary care doctors associated with Karuna Trust and BR Hills were able to gain knowledge and skills to manage both acute and chronic mental health problems, substance use disorders, intellectual disability and seizure disorders.
7. The programme appears to have reduced mortality and morbidity associated with mental health problems.
8. The success of this programme resulted in up scaling of mental health into primary care in other PHCs run by Karuna Trust.[5]
9. Many people with severe psychotic illness remained untreated despite the above-mentioned resources in the catchment area. Services for these people will require higher resources, better convergence and coordination with social and legal services.

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[5] With the support of The Banyan, Chennai and Sir Ratan Tata Trust, the Karuna Trust has begun integrating mental health care into primary care settings in all its other PHCs in Karnataka, run under public private partnership with the government. However, several challenges remain in doing this in other PHC settings due to difficulty in establishing a systematic two-way referral system for mental illnesses as well as the challenges in linking with psychiatrists for building capacity of doctors and health workers.

Conclusion

Many LMICs including India suffer from very scarce systematic evaluation of public health programmes, schemes and interventions; in the lack of this, policymaking tends to rely heavily on single success stories. On one hand, there is poor public health capacity and hence poor research outputs in this field, while on the other hand, very limited evidence for scaling up small successes mostly demonstrated by NGOs in very particular contextual conditions (Dandona et al. 2009). For example, an increasing body of literature critically looking at public–private partnerships and the role of NGOs vis-à-vis sustainability and permanence of innovative civil society/NGO-based approaches are advocating for cautious interpretation of success stories (Prashanth 2011). The descriptive case study of the Gumballi experience that we present needs to be read in that background. A scientific evaluation using health systems research methodologies are required for a systematic understanding larger lessons from the Gumballi experience (Prashanth et al. 2013; Rao et al. 2014). However, the long-term nature of engagement at Gumballi and the urgency of action on mental health at a very large scale are both important considerations underlying a descriptive approach followed here. It is possible to draw lessons on particular aspects of the Gumballi experience to strengthen the response of public health systems to the increasing unmet need for mental health care and support in the community. However, several challenges remain and need to be addressed within the larger health systems:

1. Strengthening health systems: Mental health care is an indicator of strong health systems. Care for mental health problems require patient-centred approaches as well as a good system of referral to ensure continuity of care. Given the lack of a district-level health system that is well resourced in terms of infrastructure, human resources, medicines and a system of good governance, mental health care in primary care will remain contingent on health systems strengthening initiatives.
2. Sustainability: Experiences of NGOs in showcasing good practices need to be integrated into the general health planning at the state level in order to ensure that such initiatives are sustainable and long lasting.
3. Medical records and continuity of care: Building a system in primary care based on health centre-held medical records for households or individuals is an important challenge in a country like India, where there is hardly any investment to date on building health information systems.

4. Referral and patient follow-up: Very poor follow-up on cases due to poor tracking system, rehabilitation and reintegration of the patients.
5. Limited human resources for mental health: Not only psychiatrists but also counsellors, other health workers and nurses are few and far between in India. This imposes limitations on scaling up such initiatives to *talukas* and PHCs across the country.
6. Rehabilitation and convergence: Within a system with weak investments in social welfare and social protection and poor convergence at district level between health and various other social services, organising rehabilitation for those who have been treated for mental illness is a difficult enterprise.

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Iswar Sankalpa: Experience with the Homeless Persons with Mental Illness

Debashis Chatterjee and Sarbani Das Roy

Homelessness as a phenomenon has always been with us—a stable and common finding in all communities. Homelessness as a problem probably grew with urbanization and has exploded nowadays into a very significant problem in most major cities all over the world. Usually occupying a space of invisibility and considered to be composing the dredges of society, one can often find people at street corners, moving around aimlessly, disheveled and undernourished—often visibly unwell. They occupy a mid-space between civil society and its criminal underworld—a space, more often than not, riddled with harmful addiction and anomie.

From the time humans learned agriculture and changed from nomadic to settled life, society has always been structured around the family and home. Home has come to represent, for most of us, not only a safe and healthy living space but integrated family structures and relational bonding among the family members. Alongside, there have always been few individuals in most societies who deliberately relinquished home and family bonding, on grounds of religious ideology, as a personal preference or for some other reason. Notwithstanding this, the concept of 'homelessness' always carries a negative connotation—a homeless person is one who has been deprived of a home and a family, who has lost these through some circumstance or other, and has suffered from this loss and deprivation. High levels of crowding, shortage of habitable space and high levels of economic competitiveness, with resulting

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inadequate access to basic amenities, are pushing up the rate of homelessness in most urban populations. Of course, there are a host of other factors that compound the problem of homelessness, and some of these factors may differ in different cultures and communities.

The overlap between homelessness and presence of mental illness or mental health-related problems in an individual is well recognized. The first documented case of a psychiatrist addressing the issue of homelessness and mental health was in 1906 by Karl Williams (Bhugra 2007). A very complex relationship exists between homelessness and mental illness, each causing, promoting and maintaining the other. In studies done in the USA, it has been estimated that roughly 20–25% of homeless people, compared with only 6% of the non-homeless, have one or more major mental illness (National Coalition for the Homeless, 2009); but of course cross-sectional studies may partly overestimate mental illness as the people with mental illness tend to stay homeless for longer duration of time and are more incapacitated than others. These studies usually define homelessness as 'individuals who lack fixed, regular and adequate night-time residence'. This includes unsheltered, rough sleepers, poorly sheltered, precariously housed and chronically homeless individuals. Fischer and Breakey (1985) have identified the chronically mentally ill as one of the four main subtypes of homeless persons; the others being street people, chronic alcoholics and the temporarily distressed.

Studies from the USA found that homelessness in general is more common in the male gender, in members of minority and marginalized communities, and among those affected by poverty. Presence of substance abuse and some form of personality disorder are important contributory factors to homelessness (Foster et al. 2012).

Lack of family support, hostile family atmosphere, lack of a social support system and absence of productive engagements are also of high importance. In mentally ill populations, absences of treatment and care or irregular treatment with a high rate of non-compliance are likely causes of homelessness.

It is not at all difficult to comprehend that the condition of homelessness renders the individual highly vulnerable to general ill health and morbid medical conditions. Lack of proper nutrition, lack of usual day-to-day hygiene, lack of shelter resulting in continuous exposure to vicissitudes of weather conditions and a host of infections—all compound various morbidities. They are prone to injuries, and absence of timely medical attention often leads to sepsis and other infective complications. Apart from these, lack of social networks and relational bonding with little scope for social interaction renders them isolated, lonely and prone to negative emotional impacts. Homeless people, especially females, are also often highly vulnerable to sexual and other forms of abuse.

The homeless population with mental illness represents a twice handicapped and twice marginalized sector of the society. On the one hand, presence of mental illness to a large extent deprives them of autonomy and the capacity to take care of self and, on the other hand, absence of family and home deprives them of care and access to medical help (Tripathi et al. 2013). Even within the homeless population they are looked down upon and marginalized.

Indian Perspective

The scenario described above is more or less true all over the world, but there are a few issues specific to India that need mention.

General

India is a very large and densely populated country with a land area of about 3.3 million square km and a population of about 1.27 billion according to the 2011 census. Average population density is 382.5/km^2. In term of numbers, India has a high burden of homelessness and mental illness. Compounding this, India has been classified as a lower-middle-income country by the World Bank. With less than adequate medical and other resources, India has to deal with the aforementioned problems of homelessness and mental illness. The levels of awareness concerning mental and physical health and the necessity of medical intervention in 'madness' are less than desirable. Local cultural and religious factors, on the other hand, produce their own variations in dealing with these issues. Wandering mendicants have always been a part of Indian social and religious life—be it Hindu, Buddhist or Muslim. Homeless street life, with begging and vagrancy, is treated with a higher level of cultural tolerance than is often found in western societies. This is a multi-faceted phenomenon that makes policy planning and implementation a complex issue. Most of the populace often appears to be indifferent and apathetic toward the large number of obviously distressed persons in poor health and nutrition roaming in the streets—a common sight in most Indian cities. On the other hand, relatively easily available alms at the street corners from many pedestrians make survival for these distressed persons slightly easier. In all Indian cities, many religious places dole out food on a daily basis and many homeless persons with mental illness can be found to gather at these places at these times. These factors may temporarily mitigate the humiliation, social isolation and threat experienced by such persons, and they may still be forcibly driven out from some areas or beaten or tortured, often on the mere suspicion of being thieves. This is because, though homelessness, begging and vagrancy have a relatively higher cultural tolerance in India; the same is not necessarily true for persons with mental illness. These persons often evoke negative reactions from the populace in the form of derision, unreasonable fear and aggression. At the same time, those with less disruptive behavior are sometimes pitied and given alms but mostly overlooked. It is usually the wandering homeless persons with overt disruptive behavior who receive strong negative reactions on the streets. It is interesting to note here that the Indian legal system does have an anti-vagrancy law which was directly taken from the then British laws when the colonial legal system was implemented in the mid-eighteenth century. This law is sometimes used by police to confine wandering homeless people to specified vagrant homes. The general public is mostly not aware of this law and the vagrant homes occupy a niche of silence, invisibility and lack of care.

Medical and Psychiatric Services

India is a welfare state and medical services are available for free or at a very low cost through governmental infrastructure. Unfortunately, the huge population burden, poor resources and high level of illiteracy in the populace render these governmental medical and psychiatric services rather inadequate, leading to low penetration and accessibility. The National Mental Health Program of India has been criticized as a policy that remains constrained by the existing structures of the health delivery system, occupying only a peripheral position within the total program (Jain and Jadhav 2008; Kapur 2004). It retains all the paraphernalia as well as the loopholes of the public health sector. Moreover, the conceptual frameworks informing the program conform to the simple and basic bio-medical model only and the illnesses prioritized are the ones that can be easily identified and brought under control by the primary health care staff through drug dispensing (Jain and Jadhav 2009). The National Mental Health Program does not aspire to incorporate local concerns, practices and concepts while framing a community care and support system (Kapur 2004; Jain and Jadhav 2009; Sarin and Jain 2013). The National Mental Health Program of 1982 did not include any special provision for homeless persons with mental illness. The more recent policy has tried to overcome some of these earlier loopholes, but the impact is yet to be seen. Studies undertaking critical evaluation of the National Mental Health Program and District Mental Health Program have highlighted the limitations of these programs and have tried to identify the reasons for their success or failure in specific aspects (Kapur 2004; Jain and Jadhav 2008; Jain and Jadhav 2009; Jacob 2011; Sarin and Jain 2013; van Ginneken et al. 2014).

Current mental health policy in India depends heavily on the family to initiate and maintain health service utilization. Service is, as a rule, dispensed from specified centers, be they primary health centers in rural settings, larger district hospitals or big urban general hospitals. There is hardly any attempt at outreach to patients beyond these locales (Jain and Jadhav 2008; Kapur 2004). The underlying assumption is that patients will themselves access service from these centers. In most cases, if not all, psychiatric services get translated into simple disbursal of some medicines and advice on how and when to administer them (Jain and Jadhav 2009). Naturally, for psychiatric patients, family is expected to access the service, to administer medicines and to come for follow-up care. Psychiatric in-patient services are theoretically available at district hospital level, but not all district hospitals have yet acquired these facilities. In-patient services are not available at primary health care centres.

Homeless persons with mental illness, not having family to take charge, and themselves having poor insight into their clinical conditions can hardly ever seek services from these centres. In the current scenario, the homeless are mostly left to the mercy of the police and judiciary. The combined ineptitude and heavy workload of these sectors leave the needy in a very poor state indeed. Moreover, these approaches render uprooting and forced institutionalization of these people inevitable, under acts like The Bengal Vagrancy Act (1943).

Our colonized history brings special nuances to the situation. Health services in India, as currently available, did not evolve in our cultural milieu but are imports from Britain. Whatever indigenous resources that were there were systematically ignored and alienated and an alien service concept and theoretical model was imposed on the native population. Not surprisingly, an uneasy truce has existed since and is still palpable after more than half a century of independence. Modern medicine is viewed as a necessary evil by a large part of our populace, viewed with suspicion as ‘outsider’, potentially harmful and only the last resort. Traditional healing, ayurveda, unani, homeopathy (despite the last two being equally as foreign as modern medicine), among other treatments, occupy many people’s imagination as the ‘insiders’. The colonial legacy leaves in place the categories it created, giving rise to an East–West dichotomy where the urban elite of the Indian population equates and identifies with the ‘West’ and chooses ‘Western’ or ‘modern’ medicine while the masses identifies with the ‘East’ and chooses ‘alternate’ medicines, often because these are cheaper and perceived to have fewer side effects. The clash between long-held cultural ideas around mental illness and modern medical and civic awareness needs in-depth and sustained dialogue to reach a consensus, and such dialogues will facilitate policy-making endeavors.

Iswar Sankalpa

Iswar Sankalpa is an NGO (non-governmental organization) based in Kolkata, West Bengal, India. The organization was formed in 2007 with the aim of reducing the gap that exists between the vast number of homeless persons with mental illness in the city on the one hand and the meager resources of psychiatric care available on the other. Government initiatives for psychiatric care in the city have primarily been through clinical services provided in hospitals. There is no outreach program and the onus of accessing health care is placed solely on the relatives and family members of the patient. Consequently, homeless persons have no access to psychiatric care because those who have a major mental disorder, and little or no insight, cannot be expected to do so for themselves. Before the founding of Iswar Sankalpa, there was no concerted effort to address the plight of these persons at any level. Homeless persons with mental illness are left out of all governmental policy and welfare schemes and are subject to the Vagrancy Act, criminalization and whims of the police.

A group comprising about six to eight like-minded people developed the idea of doing something meaningful for the homeless people with mental illness of the city of Kolkata. Some of us were mental health professionals, while others were from different walks of life. All of us were born and brought up in this city. Historically, Kolkata was a purely colonial city founded some 300 years ago by the British traders. From the beginning, Kolkata experienced rapid urbanization with ill-planned growth in population and infrastructure. After a formal British takeover, it was the capital of India for quite some time before Delhi took over that role in 1911. During independence and the partition of India, a huge number of people migrated from the then East Pakistan, and Kolkata (called Calcutta then) was the major focus of this mass migration. Its economic status and infrastructure suffered a severe setback. After independence, Kolkata experienced relative stagnation in economic growth and infrastructural development but continued to cater to a large migrant worker population from other parts of the state and from adjoining states, in addition to its dense population. Even now infrastructural development and health and civic amenities remain far below the level of need. Kolkata has always had a large number of slum dwellers and homeless street dwellers. Recently, there have been some developmental efforts catering to richer neighborhoods, and this has often led to evictions and increase in homelessness. We all grew up with the experience of often witnessing naked mentally ill people wandering in the streets, picking food from rotting leftovers in garbage bins or sleeping in gutters. These experiences and gaining some knowledge and skills of psychiatric illness and care motivated us to apply our limited capacities to this huge task at hand.

We formed an NGO called Iswar Sankalpa.[1] We started our project 'Naya Daur' (a 'new run') with the desire to address some of the above problems. Our immediate aim was to offer at least a modicum of civil decency and medical help to the urban homeless with mental illness, and our long-term goal was to evolve a culturally nuanced mental health curriculum and service. The project was initiated with donations from individuals, pharmaceutical companies and some businesses. Later, we obtained funds from various national and international donor agencies and continue to do so.

A few key values of our project are:

1. We do not believe in the uprooting and institutionalization of people solely in the name of medical service. That is neither dignified nor cost-effective and renders restitution and rehabilitation much more difficult. We believe that people, even if and when mentally ill, possess the right to self-determination and autonomy. It is our practice to negotiate with the people concerned at every step while providing support and care.
2. Even homeless people have their sense of belonging and possession. Such belongingness may be to a particular corner of the pavement, to a few tattered cloths and titbits they possess, and to neighbors who similarly dwell on the pavement. We respect this. While we realize that homelessness is not a self-made choice, we try to offer alternative forms of living and treatment that are then adapted and adopted according to individual preference and need.
3. We believe intervention, medical or otherwise, should be at the minimum level with minimum disruption of a person's ongoing pattern of life. Therefore, we try to provide support and care only as much as desired and accepted by the person concerned, while trying not to subsume her/his existential self under the rubric of modern psychiatric discourse.

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[1] Iswar Sankalpa literally means 'God Resolution', but the first part (Iswar/God) was unintended. It is a rule in our jurisdiction that the name of a registered society must include the first word of the street name where the office is located. It was a coincidence that our office was situated on a street with a name starting with Iswar.

4. We try to bring consultation, evaluation, treatment and care to the pavement and street corners where the concerned individual usually sleeps at night. We also try to mobilize neighbors and local community resources toward giving care to the ill.

Discussion later in this chapter of two cases—situations where we were able to bring in some improvement in the quality of life of homeless persons with mental illness—will indicate how we try to practice the above ideas in reality.

Our ideology and actual planning of the work in the streets have two objectives:

- The neighborhood is actively encouraged to take part in the care and treatment of the person concerned. This is probably the most cost-effective method of medical and psychiatric care. We hold local awareness camps and small training workshops to facilitate and enable the neighboring community in the caregiving process. Local resources in the form of food, clothing and shelter are mobilized through these interactions, and this greatly helps to enrich the service provided by us.
- Increase in face-to-face contact with persons with mental illness tends to reduce the mythical fear of the 'mad' and reduces the stigma around mental illness and persons with mental illness. Furthermore, we hope these activities will go a long way toward augmenting social bonding and sharing of responsibility.

5. We try to elicit and understand 'the meanings of madness' in the local cultural context and to bring these into our theorization and practice. In the long run, we hope to generate an alternative model of understanding mental distress as well as caregiving for the distressed—alternative to what is usually being taught and practiced in hospitals and extension clinics. In our efforts to build an alternative community care model for the mentally ill, we are always acutely aware of the fact that such endeavors need to take into account the processes of pathologization and marginalization that might be operative in such naming. We realize that we need to guard against settling for simplistic explanations and solutions. We believe a different concept of mind—its health, its pathology—born out of community experiences, perceptions and cognitions can then help to evolve a more viable notion of community care in the field of mental health. At times, a few post-graduate trainees in psychiatry have worked as volunteers with us. Exposure and experience in our fieldwork for medical graduates bring a unique cultural sensitivity and ability to contextualize essential and general services.

To further develop mental health services within urban municipal health centres, by undertaking training of physicians in mental health care, is a new project in this vein which we hope to develop.

We wished to address some of the needs of people who had no valid proof of identity and therefore could never access any health care system in the country. We wished to uphold the right to life with dignity of people who were lost within and without. In order to reach this population we realized that, firstly, we need to build a proxy family structure around the patient, and, secondly, the established structures for caregiving have to be demolished and a new paradigm must emerge wherein the power equation in the care situation will be reversed. The professional does not hold the power to heal or help. S/he can only negotiate. The decision to accept help is mostly in the recipient's domain. It is only the trust that is built in the ensuing relationship between the professional and the patient that builds the future pathway to treatment, rehabilitation and wellbeing in general.

Scope and Nature of Our Work

The basic rubric of our work is that our social workers move around in the streets observing apparently homeless people dwelling on the pavements and note down those who appear to be harboring a psychotic condition. In most situations, these persons resent intrusion and try to avoid any direct approach. Our workers, therefore, try to gather information about them–information about identity, nutrition and health status, possible disease symptoms, behavioral oddities, interaction with others, duration of being homeless and so on—from local people, often shopkeepers, rickshaw pullers, other street dwellers and so forth.

This serves a second purpose in that, during these conversations, the local people become sensitized to the plight of these persons and feel more caring toward them. They often express a spontaneous wish to help. Then they start to approach the person, striking a casual conversation, gradually bringing in topics of health and medical care.

The next step is for a psychiatrist to visit her/him there, evaluating and making a diagnosis and planning a course of treatment. All of these can only be done with the person's consent. Our social workers then again negotiate with the person about medication and with local people about taking care of the person: securing meals, clothing and regular medicine. Medicines, and often clothes and other needed things, are provided by Iswar Sankalpa.

Our social workers undertake regular follow-up visits, weekly or fortnightly. If the individual is found to have some major medical or surgical problem or is behaviorally totally unmanageable, only then do we consider removing her/him to a suitable hospital for in-patient care. In the course of our work, we realized that there are three categories of the homeless with mental illness: those who stay most of the time at a fixed place in the community for a long time and become ‘known faces’, those who wander within a closed territory but come back to the same place at a certain time of the day or night, and those who wander aimlessly and have no acceptance in the community. The last category is perceived by the community as a potential source of danger to self and others. This third category of homeless mentally ill, not surprisingly, has proved to be most difficult to include in our system of work. We also found that female homeless mentally ill persons are especially vulnerable to sexual abuse in the nights, and more often than not, we offer them safe night shelter in our center.

We currently work in about 25 wards[2] in the city of Kolkata and have reached out to over 1300 individuals in the last seven years. Of these individuals, 352 persons (89 women, 263 men) have been closely monitored and been provided with in-depth intervention. The majority of this group belongs to the ages 30–44 years group (45.7%). The others belong to the following age groups—ages 15–29 years, 12.5%; ages 45–59 years, 32.9%; and ages 60 years and above, 8.81%.

Out of these 352 people, 45 are engaged in some form of supportive employment within the community. Presently, there are 60 caregivers actively involved in community-based caregiving on a voluntary basis.

The provisional diagnosis for these 352 individuals is given as follows:

- Developmental disorders—3.41%
- Mood disorders—0.85%
- Organic disorders—0.28%
- Psychosis—92.05%
- Under Observation—3.41%

To illustrate the above ideas and methods of work, we shall now discuss two persons for whom we could bring in some improvement in quality of life. An analysis of these two cases will clarify the philosophy and abiding attitude of Iswar Sankalpa toward treatment and long-term rehabilitation of homeless mentally ill persons in the streets.

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[2] A ward is an administrative unit of the Municipal Corporation. Kolkata is subdivided into 144 wards and has a total urban metropolitan population of 14,035,959 (http://www.census2011.co.in/census/city/215-kolkata.html).

Case Study I: Arif

On a night round through the streets of Kolkata, in early August, 2007, the members of our team met a disheveled man beside a garbage dump near the Kidderpore (a locality in Kolkata) flyover. He was heard chanting verses from the Koran. It was difficult to differentiate the filth from the human amid it. We also discovered that there was a certain shopkeeper in the locality—Md Nihal—who gave him his daily lunch, there are some places where he takes his morning tea, while others give him clothes to wear. Md Nihal, a devout Muslim, believed that helping a poor man was the path to *Jannat* (heaven). After building our initial rapport with this man, who identified himself as Arif, we approached Md Nihal to help us help Arif. That very month a medical camp was organized in the locality with a local community-based organization. Md Nihal took time off from his work and brought the man to the medical camp.

Arif was given a bath and a haircut with his consent. The barber of the locality at first refused to touch him due to the filth he was covered with. Moreover, he was afraid that Arif may harm him. Another fear was that if he gave service to the likes of Arif, he would lose his regular 'normal' clientele. The barber reflected the fears of the larger community.

Our team, along with members of the community club, at first helped Arif to clean himself and to wear new clothes. This first contact that the community offered to Arif erased the myth that all mentally ill are 'dangerous' and may harm them. It was an experience of the utter vulnerability of a homeless person with mental illness. For Arif, it was the first drop of rain on the parched barren land. In the camp, our psychiatrist interviewed Arif, reached a diagnosis[3] and prescribed medicines. Our social workers talked with Md Nihal about the prescription from our doctor. Md Nihal agreed to our request to give Arif his daily dose of medicine when he came to take his lunch. Thus began the journey to recovery.

Thereafter, we found that in our daily encounters with Arif, there are people around him who do have some care and concern for this disheveled, lost human being. Over a period of one month, Arif started taking his medicines regularly and appeared more relaxed. Our social workers including a counselor would visit him regularly. He still communicated in sign language and

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[3] Arif's (name changed) Mental Status Examination stated: 'General appearance and behavior as unkempt and untidy but cooperative and communicative; speed of speech was found to be more than average—interspersed with irrelevancies; thought pattern revealed delusions of grandeur and affect was inappropriate. Auditory hallucinations were noted; cognitive function was found to be more or less intact while insight was absent.' The doctor diagnosed schizoaffective disorder.

during the period of Ramzan observed *Roza* (fasting). Within a period of five months, Arif started expressing that he felt better. He also started helping his caregiver Md Nihal, who had for so long been feeding and taking care of him. He would sometimes carry heavy loads for the shop and also deliver to customers.

Finally, after about seven months, Arif informed us that he was born in 1957 in Mumbai, but he did not want to go back home. Arif also expressed his loneliness and need for a partner. He started keeping himself clean and taking part in all the activities of Nihal's shop. After about a year, he started giving medicines and care to another homeless person with mental illness in the neighborhood. Now Arif is also a caregiver. Suddenly one day in 2009, we found him reading an English newspaper. He said his name was Suresh Kamble (a Hindu name). He spoke of his previous job in a radiology department. Even today he can still remember everything about x-ray plates. Md Nihal was in a dilemma over what will happen when Arif dies? Will he be cremated or buried as per Muslim ritual? Arif now wants to live the life of a Muslim as Nihal has been his friend—his savior. He wanted to stay with Nihal, and Nihal agreed to that. Arif is staying and sleeps at night in Nihal's shop itself.

All of Arif's needs are taken care of by Nihal, and he is now a family member. Nihal considers it his duty as a pious Muslim to serve the downtrodden. Arif, alias Suresh Kamble, has lost everything—his home, job, money, education, friends and family—to a treatable disease, psychosis. Yet with the love and care of an unknown stranger, he has found a new identity, a sense of belonging outside our common perception of 'home and family'.

Case Study II: Kanchan

A 35-year-old, Kanchan is married and has a teenage daughter and son, whom she no longer sees. Kanchan started having problems with her mind when her son was about two years old. She suddenly started singing and dancing and laughing aloud. The husband informed her brothers about her condition. After about a week of showing symptoms, her brothers brought her back with her children to see if they could help with treatment. According to Kanchan, it was her typhoid (high fever) that triggered her problems. Her fever took time to subside, and in that period she started having fits as well. She was being treated in the local hospital.

She ran away from home two or three times but was found by her family and neighbors before she could go far. Once, after continued medication, her condition improved and her brothers took her back to her in-laws' house. Her husband, a fisherman, was away at sea then. Her elder sister-in-law beat her up and drove her out of the house, keeping her children. She was found by Iswar Sankalpa staff at their medical camp at Kidderpore (a locality within Kolkata) in an incoherent state in 2010.

Commenting on her two-year stay at Sarbari, our shelter for urban homeless women with psychosocial disabilities, Kanchan said:

> Sarbari is a good place. I had no problems with the other residents. The other arrangements like food and staying was good. The staff were good to us.

With medical and nursing care she regained her mind, clinical improvement was satisfactory and she went back home after our social workers contacted the family.

She started staying with her elderly parents and four brothers. The youngest brother (unmarried) is presently working in Kerala and has built the *pukka* (a cement and brick house with tinned roof and one medium-sized room) in which she is now living with her parents in a nearby township. Her family and neighbors are helpful and supportive. For example, her mother undertakes the household work while Kanchan works.

Kanchan earns her living by making *biris* (local cheap cigarettes) at home and gets around Rs. 2000 per month. She has to spend nearly Rs. 1000 monthly on her medicines which she gets herself from a nearby government hospital after meeting the doctor every month. She engages well with her doctor who she feels is a nice person. She reported that she is now aware that she needs to see her doctor regularly and continue the prescribed medicines.

Her daughter had once come to see her with a relative. Apart from that she has no contact with her family by marriage. She says:

> I want to go back to my husband's house and be with my children. I miss my children badly.

Most of her time is spent on making *biris*. She goes around her neighborhood in her spare time. She has come to know of two other women with mental illness in the area and helped one of them to connect with her doctor.

Study of these above two cases shows points of similarity; apart from the correspondences in their accounts of affliction and the downward trajectories they lived through, there are similarities in their respective journeys toward recovery and how Iswar Sankalpa's contact with them demonstrates the ideas and ideals we discussed above.

1. In terms of offering care and rehabilitation, the principle of effecting least displacement and disruption in the current life situation, while facilitating active involvement of some members and resources in the community, is obvious in Arif's case. All the interventions and care we have provided have had a minimal impact on his ongoing lifestyle. We have tried not to disrupt his way of life while delivering mental health care. The daily care given to Arif was provided by the community, and we supplied other material resources like clothing and medicines. To begin with, an exactly similar approach was not possible with Kanchan because she was in a far worse state of health, both physically and mentally, at the time of first contact. Moreover, she was more vulnerable to sexual and other abuse in the streets. She was removed to, and cared for at, the shelter. For Kanchan it took longer, but recovery was equally satisfactory. Her and our initial efforts at rehabilitation with her family were unsuccessful, but later she was able to maintain gainful activity and support herself financially in a locality of her choice. Both Arif and Kanchan have gainful employment. From a care receiver Arif has himself become a caregiver, while Kanchan also, to some extent, tries to take responsible care of others in need.
2. Respect for the individual's autonomy and choice was maintained throughout with both Arif and Kanchan. At no point was any decision, whether about medication, accommodation, contact with respective families or employment, unilaterally imposed by the care team. At every point, it was a process of discussion, explanation, information sharing and empowering for independent decision making. Usually, we think of restoration as restoration to one's family of origin. Here we respected Arif's decision to remain with his present community. This is a different concept of restoration. Despite Arif remembering his past job and past work experience, he chose a different employment, and we abided by his decision to choose his work. In Kanchan's case, her first choice was to go back to her marital family and assume her previous role as a housewife. Despite her and our efforts, this option was not successful, and, realizing this, she herself decided to contact her parental family and chose her current situation and mode of supporting herself.

Challenges Faced and Lessons Learned

The road from mental illness to mental health is rarely linear or predictable. For one, unlike diagnosis of physical disorders—which is supported by a battery of objective indicators that can be accurately measured by state-of-the-art instruments—the diagnosis of mental disorders depends largely on the diagnostic skills of the psychiatrist and his or her ability to elicit a comprehensible account of the patient's subjective thoughts and emotions, which may be chaotic, disturbing and erratic. Treatment adherence and the chances of effective recovery are increased by a trusting physician-patient relationship, the support of family and community, and availability of the multi-faceted services that psychosocial recovery and rehabilitation require. Some disorders develop a chronic course and need treatment and support throughout the patient's lifespan. Relapses are common, and the causes for relapse could be physiological, socio-economic or multi-factorial.

The variables in the Naya Daur program are numerous—the incoherence of thought and emotional fragility of psychiatric patients are exacerbated by the instability of not having a roof over one's head, the need to scrounge for food wherever one can get it, and the itinerant nature of homelessness. Each street is different—some more hospitable to the homeless mentally ill and some less so.

Each patient is different. His/her bonds to others in the community will be as tenuous or as trusting as her experiences in the community have been, as stable or as chaotic as her current mental state is.

Trying to bring itinerant persons into a treatment regimen while respecting their autonomy in an unregulated space results in reduced drug compliance, dropouts from treatment, rehabilitation and supportive employment.

The necessity to keep side effects of medication to the minimum so that patients can go about their daily lives means administering a simplified drug routine over a longer period of time. In our experience, women patients particularly resist taking drugs once they feel the sedative side effects—it reduces their ability to stay awake and vigilant, especially from night predators.

The vulnerability of the population ranges from daily neglect and hunger to physical, sexual and psychological vulnerability, especially for women, as well as substance abuse. The lack of government facilities and services at the primary level forces the caregiving team to depend highly on voluntary donors, and if those are not available, they pay for private services. Our community care model often falls short when it comes to cases of extreme vulnerability, persons who are addicted to hard drugs or those with severe co-morbid physical illness such as tuberculosis or HIV/AIDS.

The restoration of persons to families and the findings on follow-up suggest a return to family is not necessarily an ideal solution. Most of the organization's patients come from poor socio-economic backgrounds, while some are from rural areas. Some families are not equipped—either psychologically or economically—to deal with a person who has developed a mental illness, and the quality of life for the returning person does not necessarily improve when back home. Some families give assurances of understanding, yet once home, either leave the person in a state of neglect, or ill-treat them; at best, they take them to local healers and quacks for a 'cure'. Others cannot afford to continue treatment, and even those who want to do so have no qualified medical services available in their area.

The Body–Mind Binary

One of the most severe challenges we faced in our work was to address physical illnesses where patients are both homeless and mentally ill. Government health systems have still not overcome the challenges of addressing emergency support for a mentally ill person who is in need of a surgical procedure and post-operative care. The majority of the patients' physical health needs are as acute as the mental illness is chronic. From cataract, tuberculosis or cardiovascular conditions, to simple cesarean sections for homeless women in advanced pregnancy, accessing adequate medical care is fraught with challenges. It has taken constant dialogue with the administration of hospitals, the ward staff and Iswar Sankalpa's sponsored attendants to ensure a certain modicum of relief from distress. Too often, the compartmentalization of government services—general hospitals for physical ailments and psychiatric hospitals for mental illnesses—ignores the co-morbid nature of health problems and leaves the homeless mentally ill in no man's land.

The Responsibility Dilemma

A similar compartmentalization results in both the state health department and the state social welfare department washing their hands of a population—the former department refusing to deal with them because they are homeless, and the latter because they are mentally ill. And in spite of intensive reworking of national mental health programs over the last decade, such programs will remain largely ineffective unless there is an increase in awareness of mental health issues and a corresponding rise in demand for services from communities. While sustained advocacy has led to awareness and supportive action by various government officials, the organization can only depend on their support while such officials are in office. Once they leave, or are transferred, the organization has to begin again from scratch. One such case is the Railway Police Force at Sealdah Station, which was highly supportive two years ago because of an enlightened leadership, but with a change in guard, they now look on the homeless mentally ill through a 'threat to security in public spaces' lens.

Over the years, we have tried to address the dilemma through dialogue, persuasion and awareness generation. The Social Welfare Department and the Kolkata Municipal Corporation have together supported the need for a special shelter for such persons which would take care of the recovery and rehabilitation needs of the persons under care.

Kolkata is a city with a large population (4,486,879 people) and a high population density (over 24,252 persons per square kilometer) (Census 2011). On the positive side, this is a huge pool of potential caregivers. On the negative side, the homeless mentally ill are just a drop in the ocean of people struggling for space, services and survival in an over-burdened city. Making visible the cause of the homeless mentally ill, however vulnerable they may be, is an uphill battle in a state that ranks at the bottom of a number of socio-economic indices.

The nature of the treatment and support process, and the necessary advocacy that is a parallel part of the process, places heavy demands on the caregiving team—not just in terms of legwork but in terms of personal investment in the process, innovation, adaptability, team work and the conviction to continue in the face of the hostility and lack of understanding of communities, and the utter indifference and lack of facilities in the system

The Meaning of a Home

The challenges of restoring recovered persons to their homes have left us with a new definition of a home. It is just not a structure and blood ties which ensure the feeling of belonging. A home is where there is acceptance of who you are and support for what you can be. The very conditions which make a person with mental illness escape the net remain predominantly the same when the person is restored. Intolerance for the weak is as much a part of society as is the successful reinstating that we have seen of proxy families in the community for our vulnerable patients. Thus, persons who have found acceptance in the community often do not wish to go back or search for their families of origin.

Equity

The work of Iswar Sankalpa has been grounded in equity at various levels.

- Equity in the realm of meeting the treatment gap of a section of the most vulnerable population in the country who have lost everything, including their identity, to a treatable mental illness.

- Equity in the realm of the professional and the patient power equation. It is only the patients' experienced compassion and care from the professional which builds the pathway to recovery. The professional has no other system to coerce the patient to accept treatment in the name of 'doing good'.
- Equity in the realm of benevolence toward the vulnerable in society. This work has brought to the surface that meaningful acts of kindness which can make a change in the living environment have champions among the socio-economically weaker sections of society as much as the rich and powerful. So a street vendor and a homeless beggar have also contributed to the care of vulnerable persons and shared the costs of support as much as donations from the industry houses.
- Equity in terms of gender. The work has laid bare the needs of women as well as men. The majority of organizations have focussed on the 'upliftment' of the 'second sex' and categorized them higher on the vulnerability index. However, our experience has shown that the men, who have become homeless and mentally ill often, though not as frequently as in case of women, experience vulnerability with respect to physical, sexual and emotional abuse on the street. They are sometimes subject to violence from other men, and can also be sexually molested. They can fall victim to serious physical health issues. They also become prone to economic exploitation. The value of men in society has still not broken the stereotype of a 'resource generating' machine. Thus even upon recovery, the family does not want to accept them until they 'earn their keep'. Thus, it has taken a 'habilitation oriented recovery pathway' for the men under care of Iswar Sankalpa.

Future Ways Forward

We will have to get off the beaten track and embark upon this journey without a road map to help us along. We will have to invent solutions. We have the technical skills required to achieve this goal. Do we have the wisdom to choose the right path?

The mental health scene in India at the dawn of the twenty-first century is a bewildering mosaic of immense impoverishment, asymmetrical distribution of scarce resources, islands of relative prosperity intermixed with vast areas of deprivation, conflicting interests and the apparent apathy of governments and the governed alike. In the context of the huge and perhaps unsustainable levels of over-population, the problems appear to be insoluble. Yet a solution must be found if we are to survive with human dignity. This calls for courage, vision and a vibrant spirit of innovation, unburdened with the obsolescent shibboleths of ignorance, silence and unconcern.

Dealing with the ultra-marginalized groups is not just ideological posturing from a human rights platform; it makes sound developmental sense. Mental illness and homelessness are two pervasive issues that societies need to urgently address, for both have a negative impact on the lives of individuals and communities.

In the long run, the organization hopes to offer an alternative model of understanding of mental distress as well as caregiving for the distressed. This will provide an alternative to how society perceives and deals with mental illness and mentally ill persons. It will also address the complex interactions between current social perception and the standard medical understanding of these phenomena, the latter often contributing to pathologization and marginalization of human beings. The successes of the Naya Daur program have been modest, yet by offering at least a modicum of support and medical treatment, however imperfect, to the homeless mentally ill, Iswar Sankalpa believes that it has taken some critical steps toward a creation of a humane and respectful environment for those suffering from mental disorders.

Training and sensitizing of police personnel, community leaders and community-based organizations need to be scaled up in order to generate more acceptance of the community for such people. Community caregivers need to be recognized for their contribution to the cause. We have heard of the concept of street medicine pioneered by Dr Withers in Pennsylvania[4] comprising a mobile team which addressed the health needs of the homeless population. In the city of Geel in Belgium, families routinely adopt persons from the asylum and encourage their recovery within the family, set up as an alternative to institutional care. The Government of Belgium supports this initiative with a financial compensation for the support and adoption of the mentally ill in families.[5]

It is on the streets of Kolkata that Iswar Sankalpa has initiated a process where community members extend care to the homeless mentally ill and become the proxy family without any financial compensation expected for this act of compassion. It reinforces the belief in the brotherhood of man. It dispels the myth that mental illness is always associated with violence. It addresses the stigma attached to mental illness and the belief in people's minds that a chronic mentally ill person is a lifelong burden to society. All of this happens

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[4] http://edition.cnn.com/2015/05/07/us/cnn-heroes-homeless-doctor-jim-withers/

[5] http://www.cbc.ca/news/world/psychiatric-community-care-belgian-town-sets-gold-standard-1.2557698

before the eyes of the world and not behind the walls of an asylum. The evidence thus generated is impossible to refute in the general public perception.

Conclusion

In the emerging context of Global Mental Health, the Naya Daur program offers a new perspective of addressing equity in terms of mental health care for the most vulnerable population, keeping the dignity of the individual with regard to 'choice' of place of treatment, an important step to recovery. The program has involved community and stakeholders and promoted awareness in a manner which addresses the root of the problem—that a little care and love can transform the lives of persons with mental illness. It reaffirms the essential goodness of human beings and creates bonds to break the tyranny of isolation—within and without. In the words of Harsh Mander, the Special Commissioner of Homelessness to the Supreme Court of India, Iswar Sankalpa's work 'offers lessons in Caring'.[6]

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[6] http://www.thehindu.com/opinion/columns/Harsh_Mander/lessons-in-caring/article7164480.ece

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36

Commentary on 'Case Studies of Innovative Practice and Policy' Section

Rachel Tribe

The chapters in this section present a number of case studies describing innovative mental health initiatives being conducted in a variety of different countries. Mental health is co-produced by a range of factors, some of which can be collectively captured by what is loosely defined as 'culture'. Lewis-Fernandez, chair of the Culture Subgroup of the Gender and Culture Study Group of the American Psychiatric Association fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V), describes culture as:

> an interpretive framework for symptoms, signs, behaviors which are transmitted, revised, and recreated within families and society. They affect boundaries between normality and pathology, thresholds of tolerance, coping, and interpretations of need for help, and awareness of *the* impact of culture may reduce misdiagnosis. Culture may help determine support and resilience, by contrast, it may contribute to vulnerability and stigma. It helps shape the clinical encounter and affects help-seeking choices, adherence, course, recovery. (Lewis-Fernandez et al. 2014, p. 5)

On the other hand, there are also issues relating to the reification of culture as something which is untouchable and unquestionable. Certain cultures may hold particular views around what constitutes appropriate sexuality, gender

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roles or age-appropriate behaviour, and these may be monitored in a range of ways which may be seen as antithetical to international human rights or social justice perspectives. For example, currently, 75 countries have legislation banning homosexuality and 10 have the death penalty for contravention of the legislation (Bearak & Cameron, 2016). If cultural beliefs and practices are unquestioningly accepted, this may create circumstances where two opposing views collide, those of a cultural position and those of human rights. How notions of acceptable behaviour or mental health are negotiated within low- and middle-income countries (LMICs) and high-income countries (HICs) are complex and, as this section illustrates, the bilateral sharing of ideas from both HICs and LMICs is important.

The way in which culture has been dealt with by diagnostic manuals such as the American Psychiatric Association's DSM and the World Health Organization's (WHO's) *International Classification of Disease* (ICD) has been a contentious issue. For example, earlier versions of both diagnostic manuals were criticised heavily for not adequately considering issues of culture (Mezzich et al. 1999; Summerfield 2002). In DSM-IV (American Psychiatric Association 1994), cultural differences were largely dealt with through the addition of a separate appendix, which merely listed a number of culturally specific clinical presentations and appeared to lack any link with the main text. DSM-5 (the latest iteration of DSM) (American Psychiatric Association 2013) has taken more account of cultural differences and contains the DSM-5 Cultural Formulation Interview, introduced in DSM-IV. This is discussed in more detail by Thornton in his chapter in section one of this volume.

Diagnostic Labelling

Chapters in this section raise similar criticisms about the universality of psychiatric diagnoses. For example, Banerjee and Chowdhury in their chapter highlight how culturally determined psychosocial issues such as gender discrimination and associated power dynamics, domestic violence and dowry are not adequately considered within psychiatric practice in India. Specifically, they argue that DSM/ICD diagnoses fail to account for the psychosocial dimensions which act as important risk factors for deliberate self-harm and suicide. They suggest that there is a need to think of new dimensions of distress as opposed to those which merely fit with diagnostic criteria.

Concerns have also been raised about the over-use of the diagnosis of post-traumatic stress disorder (PTSD) after natural or man-made disasters and the way in which this has been used as a marker for funders in allocating resources. As Kos (2015) writes in relation to work undertaken with Bosnian refugee children in Slovenia,

> PTSD was the entry ticket for funding internationally, we did not dare to speak about sad children, scared children or suffering children to use human language for suffering and losses. (p. 3)

Gamble in her chapter looks at the diagnosis of PTSD in Cambodia. She notes that the word 'trauma' does not translate into the Khmer language and that to try to do so may well lead to an under-representation of the prevalence and effects of trauma within the population. It is important to acknowledge that the diagnosis of PTSD can be reductionist, in that it may fail to account for normal reactions to abnormal events that have taken place. This can lead to subsequent psychological interventions being inappropriately framed. Gamble's chapter highlights that the Khmer word '*Baksbat*' is used locally which is summarised in English by the words 'broken courage' and describes a 'permanent breaking of the body or spirit' (Chhim 2012). This illustrates how when taking ideas across cultures enormous sensitivity and thought are essential—contextual variables need to be understood and accounted for. The context will vary across and within countries, so this will be important to consider for real partnership working to take place, rather than merely the imposition of ideas developed in one setting being applied generically to another. Some of the chapters in this section highlight how vital the context is for shaping understanding about what constitutes mental health, survival and human rights.

Insider and Outsider Perspectives

Some authors in this section are writing about their own countries, whilst others write about working in countries where they have developed a relationship or have links of heritage. Some of the authors are working in partnerships with local and international non-governmental organisations (NGOs) and some are working within statutory or governmental agencies. The importation of new forms of mental health care can challenge or disturb existing communities and systems in ways that might not have been considered; this often occurs despite the best intentions of expatriate workers (Tsunami Evaluation Coalition 2006; Tribe 2014). Rahman's (2008) research with female health workers in Pakistan provides an example of work where the importation of approaches originating from outside the cultural context was done in partnership with researchers or clinicians who were resident in the country where the work was undertaken, and/or had strong links of heritage to these countries.

Outsiders (e.g. mental health practitioners from HICs going to work in LMICs) may miss or overlook differences and inequalities within populations or nations, for example, with regard to minority groups, ethnicity, gender or age. However, occasionally, the perspective of an outsider can provide important insights that create space to address issues that have been largely hidden, or have been viewed as too difficult or dangerous to address openly by certain sections of a community. For example, the prevailing politics of race in the Dominican Republic is discussed by Keys and Kaiser in their chapter. They describe a short-term intervention conducted by people who were not nationals, but who bore witness to a number of issues of concern relating to anti-Haitian rhetoric in the Dominican Republic. Their position of apparent relative power and outsider status enabled them to shine a critical light on these issues and suggest changes.

Whilst being wary of the inherent risk of denying agency on the part of people from LMICs working in mental health, it is important to acknowledge that history, racism, economic factors and power differentials will be present and the associated dynamics will inevitably impact on efforts to promote mental health and wellbeing. Whilst respecting the wishes of communities may mean balancing priorities (e.g. a community's overriding wish may be for individuals experiencing psychosis to be 'taken away and dealt with' as opposed to providing care for them within the community), the ethical situation is sometimes very complex as demonstrated in the chapter by Van der Geest on her work in Nicaragua.

The Sharing of Knowledge

The sharing of knowledge and practices and the counter-flow of knowledge from LMICs to HICs may also be limited by a lack of available researchers in LMICs, a dearth of published research relating to LMICs and difficulties accessing published articles from LMICs. Ninety-four per cent of academic papers that are published in psychiatric journals come from HICs

(Patel and Sumathipala 2001). Consequently, only a small proportion of articles (i.e. 6%) emanated from researchers in countries where approximately 90% of the global population reside. There appear to be several related issues here: firstly, the lack of papers published by researchers from LMICs, and perhaps the comparative lack of studies conducted in low-income countries using the traditionally favoured methods of some journal editors such as randomised control trials which are expensive and require a certain level of infrastructure. There is a growing literature that questions the dominance of positivist research designs within mental health research (Malsom 1998; Thomas and Bracken 2004; Pilgrim and Rogers 2005) as discussed in the chapter by Mills and White in the current volume. In addition, the limitations of research designs and methodologies, including unrepresentative samples, limited ecological validity, researcher bias and associated issues, need to be taken into consideration. There may be publication biases linked to implicit forms of racism where journal editors and/or reviewers located in HICs may believe that work conducted in LMICs is not relevant to their journal or readership and therefore decisions are taken not to publish it. The outcome of this is that the status quo is upheld and it remains difficult for people based in, or writing about, LMICs to get published. Therefore, work conducted in these settings can remain hidden to those in other countries and the knowledge does not get passed on. It may also relate to the languages that journals are published in. There is a wealth of work which has been conducted which may not have spread beyond the location where it has been conducted because the resource, apparatus and infrastructure may not exist to project this potentially important knowledge. Practitioners in LMICs may also not view publication in psychiatric journals as a priority, and funding structures, time constraints and access to academic literature may also militate against this. The fact that this work is not published does not mean that it is not important in addressing mental health in a range of ways. Nor, should the fact that it may not fit with dominant or more powerful discourse mean that it is not important or effective.

Funding

The relationship between Global Mental Health (GMH) initiatives and local actors in LMICs can be further clouded when access to resources is dependent on people getting involved with particular programmes or training offered by international organisations. The chapters by Gamble, Prashanth et al., Chatterjee and Dasroy, Underhill et al., Van der Geest, Cooper et al., Carey and McDermott, Hall et al. and Stewart et al., amongst others in this section all highlight the process of negotiating between local and Western knowledge in ways that are acceptable to the local communities that the programmes work with, whilst also fitting with funders or evaluation requirements and strategies. The issue of whether interventions are driven by donor policies and goals, rather than by what a community requires, is something for all proponents of GMH to actively question. The way practitioners and donors from the West construct, understand and fund mental health work in other countries is frequently based on Western models of mental health as this is what staff working with these organisations are trained in and are familiar with. Unfortunately, funders do not always go on to investigate either the appropriateness or applicability of these models nor the methods used to evaluate mental health work. This appears to require a concerted paradigm shift if real change is to take place and the wishes of communities are to be foregrounded. It seems that we all have a professional and ethical duty to ensure that practitioners and funders are familiar with a range of models of mental health and methods of evaluation. If traditional practices and knowledge used in many countries are undermined, they would be almost impossible to get back once lost. That is not to say that all traditional practices are in the best interests of those subjected to them; for example, the chaining of people with mental health problems in LMICs has profound implications for their freedom and autonomy, and clearly infringes their rights. There is also the potential for psychiatry to be used in an unethical manner (WHO 2001; Human Rights Watch 2003; Okasha 2003). Psychiatry has a history of being used by totalitarian or unscrupulous regimes to label people as mentally ill and to incarcerate, silence or deny the rights of individuals.

Social Determinants and Structural Violence

Many of the authors of the case studies in this section report a whole raft of structural barriers and challenges faced by the projects they are writing about on a daily basis. Examples of these challenges include living with war or organised violence (Stewart et al.; Hickling); post-colonialism (Hickling); racism, social exclusion (Carey and Mcdermott; Keys and Kaiser); poverty (Hall et al., Van der Geest, Stewart et al., Prashanth et al.); homelessness (Chatterjee and Dasroy); and intergenerational trauma (Carey and McDermott).

The role of structural violence in driving mental health disparities is increasingly recognised. Structural violence is a form of violence where social institutions or structures may cause harm to people by preventing them meeting their rudimentary needs (in this case with regard to mental health and wellbeing) (Galtung 1969). The systemic nature of these difficulties may leave people feeling powerless to instigate change. In their chapter, Keys and Kaiser, reflecting on the experience of Haitians living in the Dominican Republic, highlight ways in which structural violence can be addressed at the institutional or national level. They point out that Haitians living in the Dominican Republic suffer a number of abuses, structural inequalities and forms of discrimination. They also document how this constant insecurity and stigmatisation is harmful to mental health and wellbeing. They suggest public heath campaigns be initiated to try and change the dominant discourse of anti-Haitian rhetoric in the Dominican Republic. They note that mental health provision needs to take account of the structural, socio-political and historical systems that have given rise to the suffering in the first place. Carey and McDermott also mention the importance of being mindful of the potential role of structural violence in the transmission of intergenerational trauma of indigenous Australians in Australia, whilst Hickling details how gang warfare and garrison communities are issues of concern in Jamaica. Stewart et al. working in Sierra Leone faced a specific set of challenges relating to the civil war. The perpetrators of war crimes in the country had to be re-integrated back into society, which may leave a legacy of fear, guilt, insecurity and collective trauma. This is another example of how policies and context are vitally important to the issue of GMH and raises questions of human rights and mental health.

Banerjee and Chowdhury provide an overview of the high rates of pesticide ingestion in a deltaic region of India within the rural agricultural community. Pesticides are widely available there with no or little control and are widely used by people taking their own lives. The authors argue for much better control of these as a structural intervention to reduce suicide. Also based in India, Chatterjee and Dasroy in this section describe their work with the Iswar Sankalpa, an organisation that draws our attention to the complex relationship that exists between the structural issue of homelessness and how this may interact with mental ill health, with each potentially precipitating and maintaining the other. Although structural issues of this kind exist in HICs, the magnitude of these issues in LMICs can be different. Chatterjee and Dasroy however suggest that homeless street life is treated with more tolerance in India than is often found in Western societies.

The chapters in this section highlight how structural issues are frequently encountered in addition to a lack of allocated resources or policies in relation to mental health. It seems essential that these contextual and structural issues form a central part of the wider GMH debate rather than an emphasis on diagnosis and treatment at the individual level (Fernando 2014; Tribe 2014; White and Sashidharan 2014). This focus on individual mental health delivery may not be the only way of promoting and ensuring good mental health. Some of the authors of the chapters in this section have considered many of the structural challenges thoughtfully and adapted their work accordingly. However, others appear to have largely ignored them or just mentioned them in passing.

Social determinants are acknowledged to play an important role in the development of mental health concerns and distress (WHO 2014). Whilst addressing these contextual factors may not be in the apparent remit of many mental health professionals, disregarding them and not raising matters of social justice at the micro- and macro-level might be viewed as running counter to good ethical practice and the promotion of positive mental health. In addition, there is a recursive relationship, in that people who suffer from mental health issues also tend to be less able to work (Sartorius 2007), and may become further socially isolated and excluded and slip further into poverty. Social exclusion has also been found to be particularly detrimental to mental health (Leff and Warner 2006; Social Exclusion Unit 2004).

In addition to structural issues, health policies may not always serve the best interests of the people who require help for mental illness. For example, Banerjee and Chowdhury note that the policy of the National Mental Health Programme of India appears to be constrained by some of the structures of the health delivery system, as noted by other researchers (Jain and Jadhav 2008). Bola and Atilola argue that the current Nigerian National School Health Policy (Federal Ministry of Health 2006) fails to adequately consider mental health issues. Van der Geest notes that there is no official mental health policy in Nicaragua, as mental health is not a priority and there is stigma and often considerable fear associated with mental ill health.

Cultural Appropriateness and Contextual Factors

Many of the authors in this section of the book have thought creatively about ways of working that are culturally appropriate and effective; however, some have foregrounded this more than others. For example, Professor Hickling, a national of, and working in, Jamaica, sets out the post-colonial context of his work. Hickling details the development of Dream-A-World, a cultural therapy programme for behaviourally disturbed and academically underperforming primary school children in Jamaica. This chapter describes how psychiatry was taken out of the hospital and clinic and into schools similar to the idea proposed by Bola and Atilola (see below) in their chapter on Nigeria. Hickling details how teachers, parents and children were involved in a variety of ways and given a range of new skills. The chapter presents an innovative example of how psychiatrists linked up with schools to undertake an intervention, which may have long-lasting effects on the future prospects and lives of these children. The author describes this chapter as an example of a counterflow of mental health knowledge from LMICs to HICs.

Bola and Atilola in this volume writing about Nigeria also stress the importance of cultural and contextual factors. This includes the ongoing armed conflict and the attacks on schools which have occurred in Northern Nigeria. They argue that school-based mental health programmes which are based on Western-based models were unlikely to be effective unless adapted to the local context. Carey and McDermott adopt a historical perspective to explore the antecedents of racism and continuing colonialisation of the indigenous people of Australia. They note the limitations of uncritically applying a Western model of mental health care and failing to consider the applicability of this and other models of mental health for engaging indigenous people in Australia who may have their own rich systems of considering and working with mental health issues. Some critics of GMH have called this imposition of ideas from HICs a form of medical imperialism or neo-colonialism (Summerfield 2012; Fernando 2014; White and Sashidharan 2014; Tribe 2014). Carey and McDermott describe how indigenous Australians (both Aboriginal and/or Torres Strait Islander Australians) suffer from worse mental health compared to other Australians. They consider some possible strategies for mental health services to become places with which indigenous Australians might wish to engage, looking at the importance of making them culturally appropriate and ideally more effective. They mention a number of initiatives which were initiated, but which did not prove to be sustainable for a variety of reasons.

A slightly different perspective is taken by Chatterjee and Dasroy writing about Iswar Sankalpa, an NGO working with homeless persons with mental illness in Kolkata, India. The longer-term aims of the organisation are to work towards developing a culturally sensitive mental health service as well as to undertake work that might be replicable in other countries. They present a clear and nuanced account about the contextual challenges they faced and how they dealt with these. They argue that the colonial legacy left a mental health system in India which may not be culturally appropriate to the majority of the population, many of whom prefer traditional healing. The authors describe how they work to understand ‘the meanings of madness’ within the local cultural context and to bring these into their theorising, planning and practice. They hope over time to be able to generate an alternative model of understanding mental distress and appropriate care which is useful to the people they serve and may also provide a useful counter-flow of knowledge from LMICs to HICs.

Health Pluralism

Across different societies, people draw upon a range of sources of care for psychosocial complaints, including religion, spiritual images and healers as well as the available mental health or psychosocial services. The chapters in this section by Gamble, Keys and Kaiser, and Chatterjee and Dasroy, amongst others, highlight the risk of potentially pathologising normal responses to deprivation, poverty and disenfranchisement. The meanings people or communities attribute to their ‘symptoms’ (if using a Western model of psychiatry) or ‘distress’ (if using a more ‘global model’) appear to be an important issue that requires attention by GMH.

Health pluralism, when there are a range of explanatory health beliefs and a concomitant variety of coping strategies, help-seeking behaviours and healing/treatment options (Tribe 2007), can be present in varying degrees across the world. Synthesising local cultural knowledge with Western approaches can create positive, appropriate, helpful and accessible treatment options. These possibilities are alluded to by several of the authors in this section, including those that focus on mental health in India (Prashanth et al.) and Maori mental health (Lambrecht). The chapter by Lambrecht on cultural consideration of Maori witchcraft in New Zealand provides a good example for GMH practitioners to consider how parallel yet overlapping health systems can work together. The chapter describes how the systems of Māori mental health services and allopathic government health services co-exist and on occasions intertwine. This is unusual, and Lambrecht writes about how negotiating this plurality of approaches is not always easy and can be challenging for all people involved. The acceptance of a form of health pluralism and the importance of the relative political power of the actors in this context seem important. Lambrecht reports that this has ensured that Maori ways of thinking and traditions when dealing with mental health issues are not only kept alive but practised widely.

Scaling Up and Task-Shifting

The Lancet Mental Health Group in 2007 called for the scaling up of mental health services in LMICs. 'Scaling up' means an increase in the scale on which mental health services are provided. The idea is criticised in the chapter by Banerjee and Chowdhury working in India who state that whilst they believe that this to be a noble aim, they question:

> How can mental health services be scaled up through a diagnosis based protocol solely based on DSM/ICD identification?

Scaling up is commonly done through what has been labelled as task-shifting' to people who have not been trained in the same way as mental health professionals or indeed conditioned to the same degree into a psychiatric treatment role. Prashanth et al., writing about their work in India, argue that mental health care requires 'de-professionalisation' away from specialists such as psychiatrists to health workers located in primary care and community health workers recruited from local communities. This is in line with developments in many countries as well as with WHO and Movement for Global Mental Health policy. Non-clinical workers are often able to provide accessible and patient-focused care because they have a good understanding of the community, traditions and language, and meeting with these workers may not be associated with the stigma frequently associated with psychiatric treatment. These individuals may be more aware of relevant cultural beliefs and practices and know what resources are locally available and potentially effective. In many instances, these people may be community workers who are paid less than specialist mental health professionals. These individuals can be subsequently trained in Western or indigenous psychiatric diagnoses and treatment approaches, so that they can detect and refer cases. They may also provide some treatment, for example, psychosocial and/or pharmacological interventions—though not usually in the same depth as psychiatrists or psychologists.

Scaling up is considered by Underhill et al. within their *BasicNeeds* model. They report considerable success in working with people in a range of positions from experts by experience through to governments as well as in building capacity and establishing important links and connections. They discuss the challenges they have experienced along the way at the individual, organisational and governmental level. They describe how they have developed and changed from being a delivery-oriented organisation into a support-, research- and advocacy-oriented organisation. They state this is partly due to the international funding situation and their view that the new way of working is more sustainable and beneficial. Again there is evidence here about the tensions that exist between weighing up the appropriateness of particular strategies for building capacity against the available resources, an issue that is central to GMH-related initiatives. It is also the case that pragmatic approaches to build capacity through task-shifting have potential pitfalls. For example, Ola and Atilola highlight the importance of involving faith-based organisations in mental health care in Nigeria, whilst noting the need to ensure that stigma is avoided, human rights are upheld and the terms of collaboration are clear and transparent.

Stewart et al. working in Sierra Leone describe their work with an international non-governmental organisation called *commit and act* which employs a task-shifting method. Acceptance and commitment therapy (ACT) trains non-specialist workers (e.g. local NGO workers, teachers, prison officers) to deliver the intervention. The authors note that ACT is closely related to behavioural analysis and that its main objectives are the reduction of experiential avoidance and what they call 'cognitive fusion', which is when thoughts are over-generalised. They argue that the therapy provides a unified model of behaviour change, which enables people to make positive life changes. This intervention hopes to create sources of continuous psychosocial support within communities by 'empowering individuals and groups to develop structures'. This network of support sounds like good practice and could provide a lot of empowerment and mutuality between people. It would have been helpful to read more about how local culture and practices were grounded in this work. How did people deal with mental health issues before this intervention? Also the issue of domestic violence feels rather sidestepped in the name of culture, although one example is given where it is dealt with.

In their chapter, Cooper et al. discuss how they negotiated between local knowledge and practices and global guidelines with regard to task-shifting roles for maternal mental health in South Africa. They detail a range of inventive practices and discuss their attempts at attempting to improve choices and services within a context of very limited resource provision. Similarly, chapters by Hall et al., Prashanth et al. and Van der Geest have, amongst others, all highlighted different approaches to task-shifting.

Van der Geest, for example, implemented a family-based intervention with service users and their families that provides psycho-education and peer support for people with a psychotic disorder in Matagalpa, Nicaragua. She argues that by purely focusing on clinical management of individuals, there is a risk that considerable energy and money are wasted. They approached task-shifting by working with the family and community in very inventive ways to change the community's perceptions and involve them in the care of those with a psychotic disorder.

Hall et al. in this section report on the innovative use of a range of media as well as partnerships with experts by experience from East London, England, and Kampala, Uganda. Service users from the UK connected to service users in Uganda via a web platform. The project was entitled Brain Gain and was a collaboration between the Butabika Hospital in Uganda, the East London NHS Foundation Trust (UK) and Heart Sounds Uganda. The use of peer support workers who were ex-service users to work as mentors with current patients was striking and appeared to be effective. Whilst the benefits to the current service users were clear, unexpected benefits were also noted for the peer support workers. In addition, institutional benefits within the Butabika Hospital in Uganda were also reported. The outcomes of the project were significant and included the organisation of the first user-led conference in Uganda and a heightened understanding by the Ugandan government of the importance of engaging with and utilising the lived experience of service users.

Prashanth et al. writing about the Karuna Trust clearly show how they built the capacity of primary health care workers to identify mental health problems and be the first point of contact for service users in India. This training up of people to undertake work previously undertaken by professional health workers is one of the most common forms of task-shifting. What was innovative here was how they did this and with whom. People's reliance on faith healers in relation to mental illness became apparent, so they were actively sought out and involved by the staff. The traditional and faith healers began to refer people with severe mental illnesses. The authors of this chapter have been recognised for their integrated approach to addressing development issues of indigenous tribal and rural communities in the district. This again is a form of health pluralism where effectively combining local and biomedical knowledge can be productive and serve the needs of the community.

Many of the projects mentioned could usefully be applied in other countries. This underscores the vital importance of listening to communities in developing mental health interventions. This can serve to avoid the risk of imposing models uncritically, or without due reference to the context in which people are working and the associated local specifics. There are opportunities to do things differently and for communities to think afresh about what they want with regard to mental health rather than imposing a Western model wholesale. The chapters in this section demonstrate some ways in which innovative practice may contribute to efforts being made to promote mental health and wellbeing in different parts of the world.

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