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

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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

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

[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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