

From the Editor's desk

By Kamaldeep Bhui

Globalisation and therapeutic technologies

In 2010, 700 million people had a mental disorder, and mental disorders accounted for 7.4% of the world's burden of disease, more than that of cardiovascular disease or cancer.¹ There is international concern about the growing numbers of people with dementia, and the care costs as well as the quality of care offered to older people. Premature mortality associated with mental illness remains a consistent finding on which there has been almost no progress, and the UK fares worse than many European nations.² Around the world, 80% of people with mental illness live in low- or middle-income countries that benefit from only 10% of global mental health resources.³ In low-income countries a lack of skilled professionals, poor resourcing of services and outdated concepts about illness causation mixed in with stigma and fear lead to those with mental illness being, at best, neglected or worse, chained and treated inhumanely, even if treatments are inexpensive. Task shifting is promoted as the best way to address the treatment gap, with evidence of impressive cost saving and effectiveness.⁴ Yet, despite a strong evidence base on what is effective for the recognition and treatment mental illness, most people with mental illnesses do not receive any evidence-based intervention even in high-income countries,⁵ where the costs of care are seen as unaffordable, leading to reductions in service provision and loss of services due to short-term financial crises.⁶

Why is a global response necessary, and how might it be formulated and delivered to improve the plight of patients with disabilities around the world? The global response must be grounded in national and local realities, cognisant of political systems and the priority they give to mental illness in health budgets. Other societal factors, such as extreme poverty, lack of safe and secure housing, poor sanitation, crime, the absence of good governance, and the presence of unstable governments, war, conflict and extremist inter-group hostilities, all undermine any strategic or consistent effort to remedy this gross injustice.

Some essential elements of the response include the following.

- (1) Protect and focus resources on those with the most severe disabilities who face inhumane, degrading and grossly neglectful care that results in early death and loss of quality of life.
- (2) Action to remedy the impoverished social fabric and inform political leaders charged with improving the health of the population. This is needed not only to tackle the social determinants of illness, but the societal factors that hinder recovery and compound mental distress, and institutional practices that harm patients and negate mental health and well-being.
- (3) Include due attention to tackling stigma and discrimination against those with mental illness but also in general, and to preventing inter- and intra-group hostilities, conflict and war.
- (4) Sustain the research and evidence agenda to develop new technologies and skills to prevent and treat mental illness, but also to aid in the global development and dissemination of effective interventions, including more precise and useful diagnostic systems. These technologies will need robust

testing, evaluation and perhaps modification for local circumstances before adoption.

- (5) Strengthen decision-making, empower local populations, and make good use of local assets, in order to ensure implementation.

This challenge is hindered by diverse and divergent narratives of illness causation, treatment, and a passionate discourse on what a global response looks like. Should it be a political strategy or policy that drives a commitment at the highest level, risking the adoption of universal templates that necessarily are part of a policy approach? How can local empowerment and decision-making be reconciled with a global push which might promote ill-fitting service models and concepts from more expensive and tested care systems suitable only for high-income countries? Such debates are firmly embraced by White and Sashidharan (pp.415–417) who question the value of mhGAP, a tool for improving assessment, recognition and treatment in low- and middle-income countries. This debate is not helped by diagnostic systems that are challenged for not being sufficiently neuroscientific and biological in their certainty⁷ and at the same time for being inappropriate and unhelpful in primary care and community settings³ where non-specialists will see the majority of mental distress and make decisions about intervention.

Mayou (pp.418–419) cautions against global diagnostic systems, proposing that the DSM-5 somatoform disorders criteria are 'incoherent and clinically unhelpful'. Scientific uncertainty does not help persuade governments or global movements of the need for more investment. Implicating dopamine receptors in the aetiology and pharmacotherapy of psychosis is taught to every medical student yet we find the evidence does not stack up to our popular narratives (Kambeitz *et al*, pp.420–429). In contrast, Crunelle *et al* (pp.486–487) invoke the dopamine narrative to understand impulsivity in attention-deficit hyperactivity disorder.

We need methods to assess global relevance and affordability, and more explicit statements about contexts in which interventions are effective in every scientific paper. This month's *Journal* offers evidence of many interventions: cognitive stimulation therapy for dementia (Orrell *et al*, pp.454–461), structured care interventions for reducing benzodiazepine use (Vicens *et al*, pp.471–479), a triage system to reduce hospital stays (Williams *et al*, pp.480–485). Do these have global value? Reassuringly, Husain *et al* (pp.462–470) consider culturally adapted problem-solving for self-harm and find significant benefits in Pakistan, supporting the proposition that all interventions can be adapted and offer useful tools in all nations.

We need to capture why people engage with and avoid therapeutic technologies and interrogate outcomes that speak of missed preventive or treatment opportunities; see D'Amico *et al* (pp.441–447) on the high health, social and criminal justice costs of conduct disorder; and Chen *et al* (pp.436–440) on socio-economic status and survival of people with dementia in China, where rural contexts and depressive illness contribute to higher mortality; and a study from Denmark (Qin *et al*, pp.430–435) shows that psychiatric comorbidity developing some time after physical illness contributes substantially to higher suicide mortality. Despite a passion for intervention science, we still need studies that help us better to understand the nature of mental illness, and how people move through phases of health and illness, avoiding or using clinical technologies.

1 Whiteford HA, Degenhardt L, Rehm J, Baxter AJ, Ferrari AJ, Erskine HE, *et al*. Global burden of disease attributable to mental and substance use disorders:

- findings from the Global Burden of Disease Study 2010. *Lancet* 2013; **382**: 1575–86.
- 2 Murray CJ, Richards MA, Newton JN, Fenton KA, Anderson HR, Atkinson C, et al. UK health performance: findings of the Global Burden of Disease Study 2010. *Lancet* 2013; **381**: 997–1020.
 - 3 Jacob KS, Patel V. Classification of mental disorders: a global mental health perspective. *Lancet* 2014; **383**: 1433–5.
 - 4 Buttorff C, Hock RS, Weiss HA, Naik S, Araya R, Kirkwood BR, et al. Economic evaluation of a task-shifting intervention for common mental disorders in India. *Bull World Health Org* 2012; **90**: 813–21.
 - 5 Royal College of Psychiatrists. *No Health without Public Mental Health: The Case for Action*. Position Statement PS4/2010. Royal College of Psychiatrists, 2010.
 - 6 Hindley P. Written Evidence for the House of Commons Select Committee Inquiry in Child and Adolescent Mental Health Services (CMH0173). Faculty of Child and Adolescent Psychiatry of The Royal College of Psychiatrists, 2014. Available at data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/health-committee/childrens-and-adolescent-mental-health-and-camhs/written/7668.pdf
 - 7 Phillips MR. Will RDoC hasten the decline of America's global leadership role in mental health? *World Psychiatry* 2014; **13**: 40–1.