The art of medicine

Global mental health: a failure of humanity

In the USA, the world's sliding superpower, the prisons are the functioning mental-health-care system. Somewhere between a third and half of all the homeless people in American cities suffer from mental illness. Yet balancing this abysmal record, mental health care in the USA is finally receiving renewed attention and resources aimed at closing the gap in parity with the rest of health care. The worst abuses of the mental-health-care system are undergoing near constant, if unsustained, reform and patients' rights are being better, if still not well, protected.

Turn now to the lives of people with mental illness in poor societies. Appalling, dreadful, inhumane—the worst of words pile on each other to name the horrors of being shunned, isolated, and deprived of the most basic of human rights. But this is not a crisis of the day; it has been the reality of people with mental illness for the four decades that I have been involved in global health and probably for centuries before that. I have personally witnessed individuals with mental disorders in east and southeast Asian towns and villages chained to their beds; caged in small cells built behind houses; hospitalised in for-profit asylums where they are kept in isolation in concrete rooms with a hole in the floor for urine and faeces; abused by traditional healers such that they become malnourished and infected with tuberculosis; scarred by burns resulting from inadequate protection from cooking fires; forced to dress in prison-like clothes in asylums with shaven heads and made to perform child-like dances and songs for gawping visitors; knocked to the ground and forcefully held down for electroconvulsive therapy when psychotic in an emergency room; laughed at by the police; hidden by families; stoned by neighbourhood children; and treated without dignity, respect, or protection by medical personnel. The situation has improved in cities but not that much in small towns and villages. I have read reports from Africa and Latin America that convince me that, although the details may differ, the situation of neglect and abuse is not so different.

So ground zero in global mental health is not the 15% of the global burden of disease accounted for by the cost of mental disorders; nor is it the under 2% (and often less than 1%) of expenditure on health that is estimated to go to services for psychiatric conditions in countries in Africa, Latin America, and south and southeast Asia (compared to over 10% in the USA). Nor is it the absence, or extremely small numbers, of psychiatrists, psychiatric nurses, psychologists, and psychiatric social workers in these impoverished nation states. No, bad as these indices of the deficiencies of care are, they are not ground zero. Ground zero is the routine local condition of people with mental illness (including those with dementia and autism, for example) in communities, networks, and families. It is their pain and suffering. Their moral life. The fundamental truth of global mental health is moral: individuals with mental illness exist under the worst of moral conditions.

The widespread stigma of mental illness, which prevails in countries as disparate as China, India, Kenya, Romania, Egypt, and the USA, marks individuals with severe psychiatric disorders as virtually non-human. None of the world's major religions—no matter how strong is its message of support on behalf of the most marginal and vulnerable sufferers—has been able to break this cycle of misery. Nor have modern anti-stigma campaigns and mental health laws. They have somewhat improved practices inside the asylum, but have had limited effect on those in society at large. Mental health professionals themselves and family members, moreover, have repeatedly been shown to be the most effective and efficient transmitters of stigma. Globalised cultural changes have brought about important reductions in the discrimination, fear, and isolation surrounding depression and anxiety disorders in many countries, and this is no small improvement that holds practical relevance for global mental health in general. Yet the moral conditions for people with psychosis, dementia, and mental disability remain horrendous most everywhere.

This realisation demands recognition that any effective change in global mental health will have to prioritise moral transformation as the foundation for reform of global mental health, much as it was for the reform that spurred HIV/AIDS treatment in Africa and Asia. But how is that to happen? How can delivery and management programmes for mental illness, which are so tenuous that almost none in poor societies has ever been scaled up, be expected to take on this objective? And yet, if they (and we) fail to do so, then almost certainly mental health programmes are destined to continue to fail. So what, in actual practice, can be done?

Suppose we begin not with top-down policy and programme initiatives, but rather with the on-the-ground ordinary moral experience of people in the worlds they inhabit locally. For example, in the myriad villages and towns of China, the world's rising superpower, ethnographic research documents that people disguise and hide family members with mental illness until they are no longer capable of denying psychosis. Without professional services, families usually bear the huge burden of caregiving alone. The folk healers they can turn to have little to offer that has been shown to be helpful. Finally, family members run out of energy, patience, and funds. At that point, and especially after a period of institutionalisation, protection becomes rejection. The affected person becomes a non-person in the responses of family members and outsiders

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Philippe Pinel releasing people from their chains at the Salpêtrière Asylum, Paris, 1795 by Tony Robert-Fleury

(including mental-health-care workers). No longer regarded as fully human, he or she becomes a target for abuse, discrimination, and ultimately rejection. The individual is no longer valued as an effective node in the network of connections that form social life. Social inefficacy means non-participation in social reciprocity, including gift exchange, the fundamental cultural process of living an ordinary life. It means non-participation in marriage, in work, in education, in celebrations, festivals, mourning rituals, and in ordinary experience in markets, in stores, and in other everyday activities. It is to be treated as if one didn't exist.

Small wonder, then, that the single most important element in the illness experience and treatment of those with chronic mental illness is this dangerous moral response. To call this sea of danger stigma is to trivialise its powerful effects and to be euphemistic about the enormous barriers it creates for the development of global mental health programmes that can actually address what is most at stake for sufferers and their networks. This is, pure and simply, social death.

In international law, the concept of a state's responsibility for protection of its citizens has been gaining ground. Surely the failure of protection of people with mental illness is a failure of the state? State resources must be applied to lessen this human tragedy. Even in the setting of a global economic downturn, states must be held accountable for this basic protection. That translates into protection of patients' rights. It means, for example in China, that the current emphasis of the state and its psychiatric institutions on protecting society from the potential dangers posed by people with mental illness—a threat which while real is grossly exaggerated—must be turned completely around to emphasise protection of the rights and responsibilities of patients. This requires advocacy and laws, no doubt, but these will be inadequate if they are not accompanied by a sea change in what is culturally and institutionally at stake for society in general and for the mental-health-care community in particular. If this sounds like a tall order, think of the extraordinary transformation in ethical, legal, and political responses to the AIDS epidemic, or to the epidemic of tobacco-related diseases. At their origins, these transformations grew out of new scientific evidence; yet eventually their success built on moral change in lived values over what really matters in peoples' lives. Such a moral transformation has yet to take place for those experiencing psychosis, dementia, and other mental disabilities. Bringing about such a change needs to become the central focus of institutions, professionals, and family movements in the mental health field.

There are a few green shoots that could blossom into more robust cultural change. In China and India, for example, some family groups are advocating on behalf of those with mental illness and leading psychiatric institutions have begun to include ethical issues in the training of practitioners. In Europe and the USA, narratives by people with bipolar disorder or schizophrenia, for example, are attracting a popular audience who read about the real experience of being mentally ill in their societies. While slowly but surely, global health experts are beginning to legitimise psychiatric disorders as an object of attention for global health programmes, even if they have hardly come to address the practical issues of resources for implementation. Meanwhile, in EuroAmerican and east Asian populations, the media has highlighted the new reality that people aged 85 years and older are the fastest growing population. The upshot is a huge amount of concern in popular culture about dementia. That concern focuses on both the plight of older people with dementia and the responsibilities and conflicts over caregiving facing their adult children. From invisibility and silence, dementia is moving to the centre stage of global culture. The fact that a person cannot remember and has great cognitive failures is no longer taken to erase his or her humanity or to negate his or her personhood. Of course, this transformation is in its early days and could be limited. Yet, if it continues to develop, there is the possibility that a cultural transformation in how dementia is regarded could influence how psychosis is dealt with.

It is not my intention to be overly optimistic. I only seek to call attention to aspects of global culture that seem promising and that suggest that an initial change, which is the crucial grounds for improving the moral conditions of those with chronic mental illness, may be underway. And this is what all concerned with global mental health must work to advance. The moral failure of humanity in the past does not mean we must tolerate this failure any longer.

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Further reading

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