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Global Mental Health

Milton L. Wainberg¹, Francis G. Lu², and Michelle B. Riba³

¹Columbia University/New York State Psychiatric Institute, New York, NY, USA

²University of California, Davis, Sacramento, CA, USA

³University of Michigan, Ann Arbor, MI, USA

The Global Burden of Disease Study 2010 [1] not only corroborated findings from 1990 about the significant burden of mental and substance use disorders, but it also identified that the burden of these disorders had worsened [2]. Mental and substance use disorders are now the leading cause of years lived with disability globally [3]. Lack of human resources, poor to no financing, weak governance, and mental illness illiteracy and stigma all contribute to the global mental health treatment gap, which in comparison to high-income countries is worse in low- and middle-income countries and in low-resource settings of high-income countries [4]. The goal to vastly spread access to care in low-resource settings requires multiple strategies to increase resources and capacity building to implement and scale-up effective interventions for the prevention and treatment of mental and substance use disorders [5]. In spite of this well-documented global burden of mental illness, both inherent risks for and devastating impact on other comorbidities, including communicable (e.g., HIV, tuberculosis) and non-communicable diseases, efforts to address the global mental health treatment gap have been sparse in comparison to the well-funded (non-mental health) global health programs [6–8].

Traditionally, global mental health efforts have been small appendices to health programs. In the last two decades, remarkable global mental health efforts have commenced [9]. Academic efforts comprise multiple strategies. The collection of 18 articles on global mental health in this issue of *Academic Psychiatry* presents examples of these strategies. Even though there are still insufficient opportunities for mental health research [10, 11] and inadequate quality health and mental services for those with mental disorders in all parts of the world (e.g., as described by Acharya et al. [12] in Nepal and Rissman et al. [13] in Guatemala), the global mental health landscape is finally beginning to change. Collins and Pringle [14] precisely underscore the role of careful and thoughtful research in achieving gains in global mental health by summarizing recent calls for and accomplishments of global mental health research and specific efforts of the National Institute of Mental Health (NIMH).

Sweetland et al. [15] skillfully characterize the changes that cross-cultural mental health have gone through to arrive at the current participatory and implementation-based global mental health research to practice and policy focus creating sustainable interventions to

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reduce mental health disparities grounded in social justice and human rights. Balancing traditionally opposing colonialist approaches, context and culture-specific qualitative research, and universalist epidemiological quantitative methods, the current global partnership model emphasizes an integrationist mixed-methods approach that recognizes both broad universality in mental disorders across cultures and meaningful cross-cultural variation. The new participatory and interdisciplinary perspective promotes “interdependency, bi-directional knowledge generation and transfer, and shared ownership” [15] to ensure research-capacity building in low-resource settings. For example, Smith [16] pinpoints and marvels at the “we” bi-directional learning by integrating the local meaning of *Ubuntu*, “a person is a person only through other people” [16], which took time to achieve. Lam et al. [17] and Kohrt et al. [18] expand on this need for bi-directionality and respect for the local culture and context for U.S. trainees when reporting on their exercises with a psychiatry resident-led global mental health and cultural psychiatry discussion group [17] and an interdisciplinary group discussion during the annual meeting of the Society for the Study of Psychiatry and Culture [18]. Further, Griffith et al. [19] describe how the George Washington Global Mental Health Curriculum was conceived to educate psychiatrists for service in low- and middle-income countries. Marienfeld [20] responsibly accepts the challenge and, in fact, serendipitously responds to Datta’s [21] ethical concerns about the involvement of trainees in low- and middle-income countries. Training programs have the important ethical obligation to ensure that trainees receive proper mentorship and supervision and that they are not in situations beyond their training or expertise. Acharya and Hirachan [22] also illuminate the ever-present U.S. resource of international medical graduates as excellent cultural competency partners in global mental health academic training efforts.

Like the global health field, global mental health specifically addresses the needs of low- and middle-income countries as well as low-resource settings in high-income countries. Nevertheless, two articles in this volume report on international training collaborations and experiences in high-income settings like Switzerland [23] or Qatar [24]. The former offers U.S. psychiatry residents psychiatric systems’ learning and international peer networks [23]; the latter, reports on psychiatric training as part of now more common U.S. universities’ initiatives developing branches in other countries [24].

Global mental health initiatives are taking advantage of resources not available a few years ago and more common in the global health field. Keynejad et al. [25] report on global mental health efforts as part of the King’s Tropical Health and Education Trust (THET) Somaliland Partnership (KTSP) Health Links [26], a peer-to-peer psychiatry e-learning partnership between King’s College London, United Kingdom, and Hargeisa and Amoud universities, Somaliland. In light of the continued negative attitudes towards psychiatry among medical students in high-income countries and the very limited exposure to psychiatry among medical students in low- and middle-income countries such as Somaliland, medical students were grouped into 24 pairs, one from each country, to complete ten meetings to discuss psychiatry topics. Post-participation, Somaliland students found the program academically helpful and improved their attitudes towards psychiatry; UK students described cross-cultural learning, but their attitudes toward psychiatry remained unchanged. This novel approach offers students brief, focused, online peer-to-peer

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psychiatric education opportunities that could become common both in high-, low-, and middle-income countries. Jeffee-Bahloul et al. [27] describe their experiences using another UK Internet-based program. The Syrian TeleMental Health Network provides training and clinical consultations in Syrian conflict settings. This “non-live” (i.e., asynchronous) platform allows referring providers (e.g., physicians, psychologists, nurses, non-specialized health care workers) to send data-safe clinical material about certain cases to specialists within the network to obtain specialized consultation and then supervision about their cases. This is a perfect example of Acharya and Hirachan’s [22] suggestion that international medical graduates, in this case from Arabic background, can offer the needed expert consultations and training.

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NIMH has been pivotal in global mental health implementation research accomplishments [28]. As Collins and Pringle [14] describes NIMH’s Office for Research on Disparities and Global Mental Health (ORDGMH) was created in 2010 to respond to NIMH’s global mental health mission. The ORDGMH, in collaboration with the Fogarty International Center, which is the National Institutes of Health center tasked with supporting and facilitating global health research and research training, has been charged with creating research career paths in global mental health for U.S. investigators, while also supporting research-capacity building in low- and middle-income countries as a route to building high-quality, collaborative research. At the individual/institutional-level, NIMH has funded research career paths through post-residency for psychiatrists and post-doctoral for other disciplines via institutional T32 mechanisms that provide three years of dedicated training in global mental health. Two of three T32 post-doctoral fellowships (Columbia University and Massachusetts General Hospital) funded since 2012 are described in this issue [15, 29, 30]. A third (Johns Hopkins University) was funded in 2015. NIMH also launched a global mental health mentored career development K-award initiative in 2014 and 2015 to fund early-stage U.S. investigators to prepare for global mental health research independence. Further, at the regional-level, five multidisciplinary regional Collaborative Hubs for International Research on Mental Health that were funded in 2011 and 2012 across Africa, Latin America, and Asia have increased the research base on delivery of evidence-based mental health care in low- and middle-income countries. Pilowsky et al. [31] describe the capacity-building efforts within one of these hubs. The 2015 NIMH funding opportunity “Research Partnerships for Scaling Up Mental Health Interventions in Low- and Middle-Income Countries” focused on implementing research scale-up projects to decrease the global mental health treatment gap. Five hubs are expected to be funded from this source, and a reissue of the funding source came in April 2016. Sweetland et al. [15] describe a Columbia Psychiatry NIMH/ Fogarty International Center–funded, research-capacity building project in partnership with Mozambique’s Ministry of Health and the Universidade Eduardo Modlane aiming at developing implementation mental health efforts in Portuguese-speaking, low-income African countries.

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Concerns about the low research to practice and policy yield [32] are far worse in the mental health field, even in high-income countries. The global mental health treatment gap requires investing in implementation science with participatory approaches and practice-based production of research in low-resource settings of high-income countries as well as in low- and middle-income countries. This special collection in *Academic Psychiatry* comprises a

variety of important articles focusing on stimulating constructive academic methods to address the global mental health research and treatment gap.

References

1. Whiteford HA, Degenhardt L, Rehm J, et al. Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. *Lancet*. 2013; 382:1575–1586. [PubMed: 23993280]
2. Patel V, Chisholm D, Parikh R. Addressing the burden of mental, neurological, and substance use disorders: key messages from Disease Control Priorities, 3rd edition. *Lancet*. 2016; 387:1672–1685. [PubMed: 26454360]
3. Institute for Health Metrics and Evaluation. [Accessed 12 May 2016] GBD Compare: Viz Hub. Available at <http://vizhub.healthdata.org/gbd-compare/>
4. Kohn R, Saxena S, Levav I, Saraceno B. The treatment gap in mental health care. *Bull World Health Organ*. 2004; 82:858–866. [PubMed: 15640922]
5. Chisholm D, Flisher AJ, et al. Lancet Global Mental Health Group. Scale up services for mental disorders: a call for action. *Lancet*. 2007; 370:1241–1252. [PubMed: 17804059]
6. Prince M, Patel V, Saxena S, et al. No health without mental health. *Lancet*. 2007; 370:359–377.
7. Collins PY, Holman AR, Freeman MC, Patel V. What is the relevance of mental health to HIV/AIDS care and treatment programs in developing countries? A systematic review. *AIDS*. 2006; 20:1571–1582. [PubMed: 16868437]
8. Sweetland A, Oquendo M, Wickramaratne P, Weissman M, Wainberg M. Depression: a silent driver of the global tuberculosis epidemic. *World Psychiatry*. 2014; 13:325–326. [PubMed: 25273311]
9. Becker AE, Kleinman A. Mental health and the global agenda. *N Engl J Med*. 2013; 369:66–73. [PubMed: 23822778]
10. Razzouk D, Sharan P, Gallo C, et al. Scarcity and inequity of mental health research resources in low-and-middle income countries: a global survey. *Health Policy*. 2010; 94:211–220. [PubMed: 19846235]
11. Tomlinson M, Rudan I, Saxena S, Swartz L, Tsai AC, Patel V. Setting priorities for global mental health research. *Bull World Health Organ*. 2009; 87:438–446. [PubMed: 19565122]
12. Acharya B, Hirachan S, Mandel JS, van Dyke C. The mental health education gap among primary care providers in rural Nepal. *Acad Psychiatry*. 2016 (in press).
13. Rissman YZ, Khan CT, Isaac SK, Paiz JA, DeGolia SG. Developing a mental health curriculum to build capacity and improve access to mental health care in rural Guatemala. *Acad Psychiatry*. 2016
14. Collins PY, Pringle BA. Building a global mental health research workforce: perspectives from the National Institute of Mental Health. *Acad Psychiatry*. 2015
15. Sweetland AC, Oquendo MA, Carlson C, Magidson JF, Wainberg ML. Mental health research in the global era: training the next generation. *Acad Psychiatry*. 2015
16. Smith MK. Bringing back Ubuntu. *Acad Psychiatry*. 2015
17. Lam JSH, Gajaria A, Matthews DM, Zaheer J. Bridging cultural psychiatry and global mental health: a resident-led initiative. *Acad Psychiatry*. 2016 (in press).
18. Kohrt BA, Marienfeld CB, Panter-Brick C, Tsai AC, Wainberg ML. Global mental health: five areas for value-driven training innovation. *Acad Psychiatry*. 2016
19. Griffith JL, Kohrt B, Dyer A, Polatin P, Morse M, Jabr S, et al. Training psychiatrists for global mental health: cultural psychiatry, collaborative inquiry, and ethics of alterity. *Acad Psychiatry*. 2016
20. Marienfeld C. Considerations of ethics while allowing flexibility for trainees: the model and the rationale for the model of the Yale global mental health program. *Acad Psychiatry*. 2015
21. Datta V. The problem with education in global mental health. *Acad Psychiatry*. 2015
22. Acharya B, Hirachan S. Including international medical graduates in global mental health training. *Acad Psychiatry*. 2015

23. Schneeberger AR, Weiss A, von Blumenthal S, Lang UE, Huber CG, Schwartz BJ. Beyond watches and chocolate—global mental health elective in Switzerland. *Acad Psychiatry*. 2014
24. Kronfol Z, Al-Amin H, Haddad N, Streletz L, Gordon-Elliott J, Marzuk P. Teaching psychiatry on the global scene: the Cornell University experience. *Acad Psychiatry*. 2015
25. Keynejad R, Garratt E, Adem G, Finlayson A, Whitwell S, Sheriff RS. Improved attitudes to psychiatry: a global mental health peer-to-peer e-learning partnership. *Acad Psychiatry*. 2014
26. Leather AJ, Butterfield C, Peachey K, Silverman M, Sheriff RS. International Health Links movement expands in the United Kingdom. *Int Health*. 2010; 2:165–171. [PubMed: 24037696]
27. Jefee-Bahloul H, Barkil-Oteo A, Shukair N, Alraas W, Mahasneh W. Using a store-and-forward system to provide global telemental health supervision and training: a case from Syria. *Acad Psychiatry*. 2015
28. National Institute of Mental Health. [Accessed 12 May 2016] Initiatives to Advance Global Research on Mental Health and Substance Abuse, 1990-2014. Available at <http://www.nimh.nih.gov/responsive/map.shtml>
29. Magidson JF, Stevenson A, Ng LC, Hock RS, Borba CP, Namey LB, et al. Massachusetts General Hospital global psychiatric clinical research training program: a new fellowship in global mental health. *Acad Psychiatry*. 2015
30. Ng LC, Magidson JF, Hock RS, Joska JA, Fekadu A, Hanlon C, et al. Proposed training areas for global mental health researchers. *Acad Psychiatry*. 2016
31. Pilowsky DJ, Rojas G, Price LN, Appiah-Poku J, Razzaque B, Sharma M, et al. Building research capacity across and within low and middle-income countries: the collaborative hubs for international research on mental health. *Acad Psychiatry*. 2016
32. Green LW. Making research relevant: if it is an evidence-based practice, where's the practice-based evidence? *Fam Pract*. 2008; 25(suppl 1):i20–i24. [PubMed: 18794201]