Challenging the globalisation of biomedical psychiatry

For over 100 years biomedical psychiatry has dominated the way people throughout the western world understand their sadness and distress, despite the lack of empirical evidence that distress has a biological basis. Now, the interests of the global pharmaceutical industry and trans-national professional elites such as the World Health Organisation and the World Psychiatric Association are extending these biomedical accounts across the globe. This paper briefly describes biomedical psychiatry and its origins before considering how this project is closely aligned to the interests of the pharmaceutical industry. It ends with a call for a new agenda in mental health, driven by the concerns and interests of ordinary people in local communities, and an outline of recent developments in Britain and elsewhere that illustrate this challenge to the biomedical hegemony.

I n September 2005 the 13th World Congress of Psychiatry will take place in Cairo under the title Five Thousand Years of Science and Care: Building the Future of Psychiatry (XIII World Congress of Psychiatry, 2005). Following the 12th World Congress in Yokohama in 2002, a more appropriate subtitle for this year's event might be Building the Future of the Pharmaceutical Industry. The 2002 congress included satellite symposia organised by pharmaceutical companies. Some dealt with the transcultural aspects of diagnosis: 'Psychiatric treatment of mental health disorders across populations – do east and west meet?' (Pfizer), 'Transcultural aspects of depression and anxiety disorders' (GlaxoSmithKline), 'Recognition and treatment of depression: differences between American, European and Japanese practices' (Janssen), 'Eye on Asia: Reducing the socio-economic burden of depression' (Wyeth). Others dealt with the management of psychosis: 'Raising the level of schizophrenia care' (Janssen-Cilag) and 'Optimising patient outcomes in schizophrenia' (Pfizer). The main sponsors of the 2005 congress are Eli Lilly, Bristol-Myers Squibb and Otsuka Pharmaceutical. Nationally and internationally, the interests of psychiatry and the pharmaceutical industry are becoming ever more tightly-woven.

In this paper we examine these developments critically. Biomedical psychiatry has enormous power to shape our understandings of ourselves – especially our sadness and distress. We see the globalisation of this view as undemocratic, unsustainable and without a clear ethical focus. There is, in our view, an urgent need for a new agenda in mental health, driven by the concerns and interests of ordinary people in local communities.

What is biomedical psychiatry?

Psychiatry has provided fertile soil for endless theories about distress and madness. To some extent this reflects a fundamental feature of Western medicine, heir as it is to body–mind and mind–society dualisms (see Bracken & Thomas, 2005). Until recently, psychiatry attempted to contain these dualistic tensions within the biopsychosocial model, but recent years have seen the emergence of new discourses, such as clinical neuroscience, that are eclipsing the psychological and the social.

Biomedical psychiatry involves the use of science and technology to develop causal accounts of distress, which is formulated in terms of illness categories, such as schizophrenia. Schultz and Andreasen (1999) put it this way:

'Current research seeks to detect causal mechanisms in schizophrenia through studies of neural connectivity and function, as well as models of genetic transmission, such as polygenic models of inheritance in genetic research. Potential genes have been identified that may confer vulnerability to the illness, perhaps in conjunction with environmental factors. Neuro-imaging research with magnetic resonance imaging and positron emission tomography has investigated differences in volumes and functional dysregulation in specific

Philip Thomas
Senior research fellow
Centre for Citizenship and Community Mental Health, Bradford University

Patrick Bracken
Clinical Director, West Cork Mental Health Service, Ireland

Paul Cutler
Interaction, Kent

Robert Hayward
Interaction, Kent

Rufus May
Clinical psychologist, Assertive outreach team Bradford District NHS Care Trust

Salma Yasmeen
Manager
Sharing Voices, Bradford

Correspondence to:
Phil Thomas
Senior research fellow.
Centre for Citizenship & Community Mental Health
School of Health Studies
University of Bradford
25 Trinity Road
Bradford BD5 0BB
e p.thomas@bradford.ac.uk

neural sub-regions. Areas studied include the frontal and temporal cortex, the hippocampus, the thalamus, and the cerebellum. Despite these advances, treatment of symptoms and psychosocial and cognitive impairments remains only partially successful for many patients.'

Biomedical psychiatry involves the application of technology from a wide range of scientific disciplines, including genetics, molecular biology and neuroscience. As the authors' final sentence truthfully acknowledges, it has delivered limited therapeutic benefits. One reason is that, despite the huge sums of money expended on such research, the causes of schizophrenia remain unknown:

> 'In the absence of visible lesions and known pathogens, investigators have turned to the exploration of   models that could explain the diversity of symptoms through a single cognitive mechanism.' (Andreasen & Black, 2001)

and

> 'Many candidate regions [of the brain] have been explored [for schizophrenia] but none have (sic) been confirmed.' (Andreasen & Black, 2001)

To put it another way: 100 years of scientific research have failed to demonstrate replicable abnormalities in the brains of people identified as suffering from schizophrenia.

The word we want to draw attention to in the extract from Schultz and Andreasen is 'causal', for this yields an important clue about the heritage of biomedical psychiatry. The belief that it is possible to develop causal accounts of human experience is an important feature of positivism, which stresses the unity of natural and human sciences. In psychology and psychiatry the use of positivism assumes that human experience can best be approached through the formal methods of scientific inquiry. It is important to understand the origins of such ideas. Both positivism and psychiatry share common roots in the historical period of the European Enlightenment. Elsewhere, Bracken & Thomas (2001) have described how Enlightenment (or the Age of Reason) preoccupations have shaped modern psychiatry (see also table 1). There are three strands to which we want to draw attention. The first is the role that psychiatry came to play in maintaining an orderly society through the Great Confinement (Foucault, 1967; see also Thomas & Bracken, 2004; Bracken & Thomas, 2005). The second is the importance attached to a search for technological solutions to human problems, and the third is a preoccupation with the self, its depths, and individual subjectivity. This emerges in psychoanalysis,
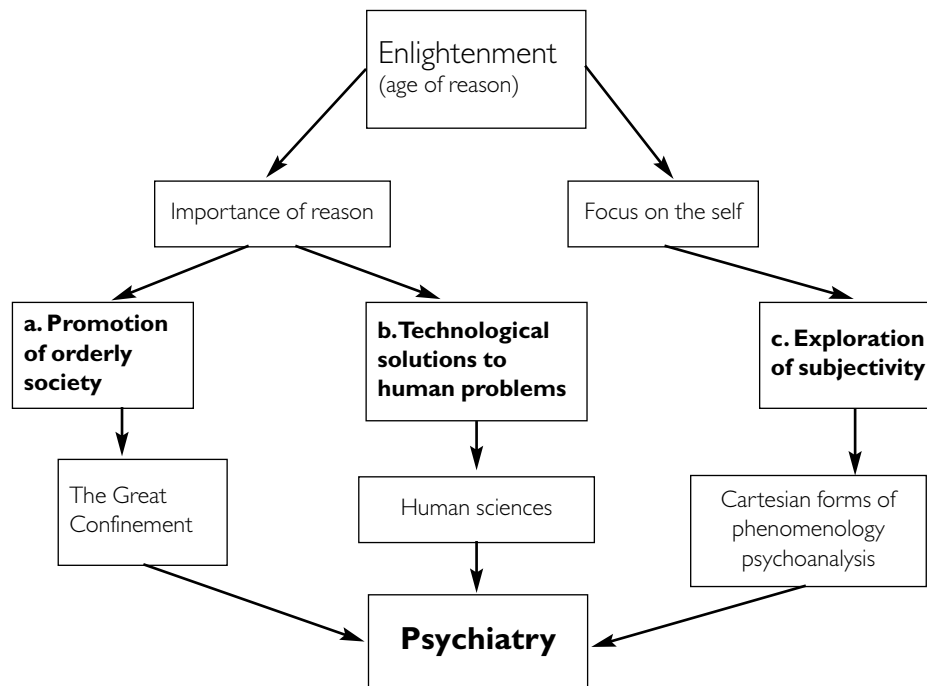
cognitivism, and the variety of phenomenology that has become highly influential in psychiatry. All seek scientific accounts of experience in terms of 'interior' processes located in the depths of the individual mind. These three themes are woven together in the modernist project of psychiatry. These origins are deeply rooted in a particular epoch of European history, and it is important to bear this in mind throughout this paper.

It is also important that we dwell on the role of phenomenology in psychiatry, because of the role it has come to play in shaping the way the profession relates to the experiences of madness. We have covered this in detail elsewhere (Bracken & Thomas, 2005, see especially chapter four), drawing attention to a distinction between the phenomenology of Karl Jaspers' general psychopathology, heavily influenced by the work of Edmund Husserl on the one hand, and the hermeneutic phenomenology of Martin Heidegger on the other. The former sets out to be a rigorous science that approaches experiences of suffering by wrenching experience out of the cultural and personal contexts in which experience is embedded. This results in a preoccupation with the form of experience rather than its content. Hermeneutic phenomenology is primarily concerned with how we make sense of our experiences, and how the world stands out for us in our attempts to make it intelligible. This means that individual experience is inseparable from the contexts (personal narrative, cultural, political and historical) that render experience meaningful and understandable. This, as we shall see, has important implications for the way we should be responding to states of distress and madness. It implies that responses and support networks from within the person's own cultural setting are more likely to facilitate understanding and recovery.

The globalisation of biomedical psychiatry
In economically advantaged (EA) countries, psychiatry is a powerful force that dominates the way we talk about ourselves, our relationships and emotions (Rose, 1986). This is now being extended to economically disadvantaged (ED) countries. The World Health Organisation's mental health Global Action Plan (mhGAP) (World Health Organisation, 2002) is a global strategy to make governments more aware of mental health problems, and to get them to spend more money on psychiatric services. This is a mental health promotion strategy aimed at educating and persuading hundreds of millions of people across the planet about their mental health, but it articulates a very limited view of how we are to understand 'mental health'. It asserts that psychiatric disorders are universals that: '450 million people suffer from mental disorders in both developed and developing countries,' and: 'One in every four people…develop one or more mental disorders at some stage in life.' (WHO, 2002)

The strategy emphasises the need for action to

Table 1: Enlightenment influences on psychiatry (Bracken & Thomas, 2005)

```
                          ┌─────────────────────┐
                          │   Enlightenment     │
                          │   (age of reason)   │
                          └─────────────────────┘
                          ↙                     ↘
           ┌──────────────────────┐      ┌──────────────────────┐
           │ Importance of reason │      │   Focus on the self  │
           └──────────────────────┘      └──────────────────────┘
            ↙                    ↘                          ↘
┌───────────────┐   ┌──────────────────┐      ┌──────────────────────┐
│ a. Promotion  │   │ b. Technological │      │ c. Exploration       │
│ of orderly    │   │ solutions to     │      │ of subjectivity      │
│ society       │   │ human problems   │      │                      │
└───────────────┘   └──────────────────┘      └──────────────────────┘
        ↓                    ↓                          ↓
┌───────────────┐   ┌──────────────────┐      ┌──────────────────────┐
│ The Great     │   │ Human sciences   │      │ Cartesian forms of   │
│ Confinement   │   │                  │      │ phenomenology        │
│               │   │                  │      │ psychoanalysis       │
└───────────────┘   └──────────────────┘      └──────────────────────┘
            ↘                ↓                  ↙
              ┌──────────────────────────┐
              │      Psychiatry          │
              └──────────────────────────┘
```

counter the economic impact of psychiatric disorders. Those who suffer from mental health problems, and their families, experience 'reduced productivity' and loss of income, and face 'catastrophic' health care costs. The WHO asserts that progress in biomedical psychiatry will rectify this, bringing new hope through treatment advances, dispelling ignorance and thus stigma:

> 'We know that mental disorders are the outcome of a combination of factors, and that they have a physical basis in the brain.'

It claims that effective treatment can result in successful symptom control in 70% of cases of depression and schizophrenia, and the continuation of treatment substantially reduces the risk of recurrence. It points out that drug treatment is cheap in many countries: it costs $5 a month to treat schizophrenia and $2-3 for depression. It proposes anti-stigma campaigns to change public attitudes, aimed at:

> '…consumers, families and their organisations, who need to be sensitized about mental disorders, available treatment, and their rights in the service system.'

The WHO Project Atlas 2000-2001 (WHO, 2001; 2005) surveyed 185 countries covering 99.3% of the world's population. The governments of two fifths of these countries had no mental health policies. In more than a quarter, patients had no access to basic psychiatric drugs in primary care. More than 70% of the world's population had access to less than one psychiatrist per 100,000 people. The mhGAP initiative proposes partnerships with other groups, including UN organisations, the World Bank, private industry, academic institutions and NGOs, to ensure that all governments have strategies to increase the availability of psychiatric treatment in primary care, improve public education about psychiatric disorders, and establish national policies and programmes in mental health.

Project Atlas carries enormous weight in the global community, and WHO continues to base much of its strategic planning on the survey.[1] Jenkins *et al* (2005) have described its limitations. For example, its statistical base is misleading and questionable. It doesn't include social care homes in which many people are incarcerated, despite the fact that in many countries such institutions are often the main source of compulsory admissions. The conditions in many of these institutions are appalling. An investigation by the

---

[1] The latest update Mental Health Atlas 2005 is at www.who.int/mental_health/evidence/atlas (accessed 1 August 2005).

Mental Disability Advocacy Centre (MDAC, 2003) revealed that four European Union accession countries, including the Czech Republic and Hungary, were using caged beds in their psychiatric institutions, despite ministerial denials and the representations of WHO officials (Hungary subsequently banned their use).

We question the ability of global strategies like Project Atlas to deliver large-scale, ethical and sustainable support for people who experience distress. Such programmes fail to acknowledge the economic, political and cultural dimensions of mental health care. Project Atlas foregrounds biomedical understandings of distress, and thus the meanings and interpretation of distress are downplayed and regarded as secondary to conquering the 'scientific' challenge of mental illness. Of course, it is vital that everything possible is done to improve the lives and circumstances of those who experience psychosis and distress, and organisations like the WHO have a key role to play in this. However, we argue that the WHO, in foregrounding the role of biomedicine, is inadvertently playing into the hands of a different set of interests.

The global pharmaceutical industry

We are told that the pharmaceutical industry invests huge sums of money in developing new drugs. A close examination of the figures reveals a different picture. In terms of annual profits, the pharmaceutical industry is the second largest sector of the US economy, second only to armaments. Despite the economic uncertainties of 2001, the pharmaceutical industry maintained its position in the Fortune 500 list of most profitable companies in 2002.[2] On average, company profits fell 53% in 2001, but the profits of the top ten US pharmaceutical companies rose by 33%, to $37.2 billion. They were the most profitable sector in the US, reporting a profit of 18.5 cents for every dollar of sales. The financial strength of the industry reflects a 30-year trend. The so-called decade of the brain, declared by US president George Bush on 17 July 1990, saw a 50% increase in drug company median profit as a percentage of revenue (Fortune, 2002a). Of particular interest is the role of blockbuster drugs: those with annual sales in excess of $1 billion. In 2001, the number of these drugs almost doubled over the previous year. These 29 drugs had an extraordinary impact on the market, accounting for over a third of all sales. They were the most expensive drugs, with an average prescription price of nearly double the national average. The advertising budget of each of the seven most heavily advertised drugs topped that of Nike ($78 million).

Drug companies justify their enormous profits with the claim that their technology is a risky business. Extraordinary levels of revenue are required to fuel the R&D costs involved in developing new drugs. In fact,

the Fortune 500 report shows that they plough far more of their revenue into profits and marketing than they do into R&D. On average, drug companies directed 18.5% of revenue into profits in 2001, as against only 12.5% of revenue on R&D. Thus the idea that companies place R&D costs before and above profit and marketing is simply not borne out by the figures.

Joanna Moncrieff has described how the boundary between science and marketing has become muddied in the pharmaceutical industry:

'… marketing strategies now include attempts to shape psychiatric thought through the academic arena. This is done by a strategy that is conceived long before a product is officially marketed and may involve the promotion of disease concepts and their frequency. A recent guide to pharmaceutical marketing suggests the need to "create dissatisfaction in the market", "establish a need", and "create a desire".' (Moncrieff, 2003)

Unholy alliances have emerged between mental health professionals, users, government and the pharmaceutical industry, reflecting the interplay of mutual interdependencies and chains of interest. In the context of globalisation, these multi-layered relationships may vary according to local contexts. For example, in central Europe the pharmaceutical industry has, on occasions where it serves its purposes, funded user groups and grassroots advocacy to lobby and campaign for greater access to psychiatric drugs. At other times industry and governments have colluded in illegal drugs trials, as testified by Hungarian survivor and activist Gabor Gombos, who described to BBC Radio 4 in February 2004 some of the practices he had encountered. One included moving patients from Estonia to Hungary to by-pass inquisitive officials and to enable dubious drug trials to be completed away from Estonian scrutiny. In India, on the other hand, the government has been keen to protect its budding pharmaceutical industry, which produces bootleg medication, and has resisted the challenge of trans-national companies to respect their international patents. On the streets of India and in the (private) clinics of Pakistan cheap versions of the latest psychotropic drugs are readily available. This may or may not be in the interests of South Asian users and their families, but it indicates the complex dynamics of these relationships.

The globalisation of biomedical psychiatry can also be seen as part of a relentless modernist agenda driven by the ideal of progress through the never-ending growth of technology. Technology has brought great benefits in health, but it also raises questions of an ethical nature. So far, our analysis suggests that as well as being driven by the ideal of global health

---

[2] Fortune is the American business magazine that monitors the progress of the world's richest companies. The material on the pharmaceutical industry reported here derives from data accessed from Fortune (2002b).

improvement, the extension of psychiatry serves well the interests of the pharmaceutical industry and powerful professional groups like the World Psychiatric Association. This raises the issues of sustainability and democracy. Whether in the guise of new drugs or new therapies, technology is costly. How long should we reasonably be expected to go on paying for these developments, especially when their effectiveness is at best limited (Schultz & Andreasen, 1999)? How are economically disadvantaged countries supposed to fund these developments, given the competing priorities of providing food and combating illnesses like AIDS? More fundamentally, perhaps, what are the consequences of the world becoming ever more dependent on technological responses to distress, dislocation and alienation? These questions raise the need for a democratic debate about our emotions.

Sustainability and democracy in health
Price *et al* (1999) have described how the forces of trans-national capitalism, led by the World Trade Organisation, have shaped domestic health policies in EA countries. In England, the controversial private finance initiative (PFI) gives the private sector access to public funds for health and social care. As a result, the state no longer owns the new hospitals, which are leased out to the NHS by the private companies who own them, and who can use them for other purposes when the lease expires. This is but one example of how global capitalism is changing the face of health care. According to Price *et al*, this jeopardises local accountability, and represents a fundamental change in the value base of health care away from local democratic control towards consumer choice in health care. This can be seen in the emphasis on league tables and performance measures that dominates the NHS. They conclude that, as far as health care is concerned, globalisation represents a threat to '… universal (health) coverage… equity, comprehensive care, and democratic accountability'.

Health improvement through biomedicine is expensive. Let us consider the situation in Britain. When it came to power in 1997, the Labour government pledged a sustained increase in spending on the NHS over and above inflation until 2008. Nearly ten years into this enormous expansion it is clear that the service cannot go on growing endlessly. In March 2001, the chancellor appointed Derek Wanless to review the long-term funding of the NHS. His final report made a number of recommendations (Wanless, 2004), the first of which is highly pertinent to our arguments:

'After many years of reviews and government policy documents, with little change on the ground, the key challenge now is delivery and implementation, not further discussion. An NHS capable of

facilitating a "fully engaged" population will need to shift its focus from a national sickness service, which treats disease, to a national health service which focuses on preventing it.' (Recommendation 9.1)

In other words, the report proposes a fundamental shift in ethos, with a move away from the ideology of disease and its treatment to that of public health and disease prevention. Setting aside any other considerations, the basic economic facts suggest that a health service that prioritises disease, underwritten by biomedical models of illness and high-tech treatments, is not sustainable, given the current levels of growth and the likely resource base over the next 20 years. An alternative approach is a public health model that recognises the importance of dealing with health inequalities and other environmental factors such as smoking and obesity, as well as engaging actively with patients and communities to involve them in decisions about health priorities. The summary of the report paints a wide definition of public health as:

'… the science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society, organisations, public and private, communities and individuals.'

It attaches particular importance to the 'full engagement' of the population in order to improve 'health literacy', especially in chronic conditions.

Wanless draws many conclusions, many of which deal with the future funding of the NHS. One way of interpreting his report is that the public must temper its belief that progress in health can only be achieved through continuing developments in science and technology. We want to set this in a global context. The sustainability of health care in EA countries is set in an international context in which there are gross inequalities in wealth, and where interpretations of distress are dominated by the interests of the global pharmaceutical industry.

Local developments in a global context
Our contention is that biomedical psychiatry is a hegemonic universal discourse driven by the interests of the pharmaceutical industry and powerful professional elites. There are two points to be made here. The first involves the potential harm that the globalisation of biomedical psychiatry may cause (see with respect to children, for example, Timimi, 2005); the second concerns the view (articulated by McKenzie *et al*, 2004) that EA countries have much to learn from the ways that ED countries have had to adapt western models in the light of their economic and political circumstances.

We regard the globalisation of biomedical psychiatry as a form of neo-colonialism; it involves the imposition of

western values, customs and practices on non-western cultures. The baleful consequences of earlier forms of colonialism in mental health have been well-documented. Higginbotham and Marsella (1988) described the uniformity of psychiatric care in the capital cities of south east Asia, despite the large social, cultural and linguistic differences. This 'homogenisation of psychiatry' was brought about through the inputs of earlier generations of western psychiatric experts, which resulted in a psychiatric practice that looked to the west for its conceptual foundations and for ideas about innovation and progress. This created a homogeneous mental health system with:

> '… [a] common language uniting international and local levels [deriving] from shared assumptions about the shared nature of psychopathology, the use of standardised assessment, and the efficacy of scientifically derived bio-medical or bio-behavioural interventions.'

These services had unanticipated and negative consequences, with a deterioration in the care received by many people. Higginbotham and Marsella described serious 'after-shocks' within local cultural systems:

> 'The inability of local centres to generate research and evaluate services, in combination with pervasive resource and personnel deficiencies, means that hospitals become custodial end-points for chronic cases. Drugs and electric shock treatment are overused and non-psychotic patients are drawn into hospital work forces.'

The diffusion of western-based knowledge promoted professional elitism and institutionalised responses to distress, and undermined local indigenous healing systems and practices. In reality: 'The net result of introducing a formal treatment system for psychological problems is less help for those in need.'

Recently the WHO has acknowledged the limitations of importing the discourse of post-traumatic stress disorder (PTSD) in post-disaster situations (van Ommeren et al, 2005). International responses to war and disruption that prioritise technological interventions for PTSD are ethically questionable in such situations, given the need to re-build human and community resources, and for simple public health interventions to stave off disease.

The situation is beginning to change. McKenzie et al (2004) have pointed out that, although services in ED countries are under-resourced, through ingenuity and the application of local knowledge they have been able to develop creative and adaptable services. They argue that the objective of traditional forms of care is not to transfer social responsibilities from the state to under-resourced families and communities, but to recognise the important contribution that social capital makes to a nation's wealth. This is vitally important and, furthermore, it applies with equal force to EA countries. It means that we should see traditional forms of care as being dependent on human resources that must be nurtured and developed in a sustainable manner. They are not 'cheap' alternatives to technological psychiatry. In other words, within the economic constraints that apply in particular cases, all countries have to make choices about the extent to which they invest in local resources, such as traditional forms of care, as opposed to high-cost technological resources. There has to be a balance struck between state responsibility and empowering and enabling local communities to take the lead in responding to their health and mental health needs. We agree with McKenzie et al's analysis, that investment in social capital must be exactly that – the investment of resources that support and encourage grass-roots initiatives in mental health. Community development is a valuable way of achieving this.

But community activation and development will remain limited in its scope as long as it consists of small projects working in isolation. If the might and power of biomedical psychiatry is to be challenged, it is vital that ways are found to draw local developments together, and to co-ordinate their campaigning activities on governments and trans-national organisations. NGOs like Interaction are encouraging local groups of mental health service users and communities to question the imposition of global initiatives by organisations like the WHO. Interaction (2005) argues that global initiatives reproduce and maintain existing power relationships, support the status quo and thus help to sustain gross socio-economic disparities that have a particularly malign influence on people who experience mental health problems, thereby helping to perpetuate social exclusion. These power relationships are, as we have seen, rooted in colonial and neo-colonial practices that are patriarchal, elitist and insensitive to cultural difference. Historically, top-down (or global) approaches to the development of mental health policy have consistently failed to meet the needs of local communities:

> 'Notwithstanding best intentions, neither governments nor most international agencies have achieved goals or expected results… In transitional economies [eg. countries in the former communist bloc, and the Balkan states] and developing countries, this presents an additional challenge in promoting and managing alternatives to old orthodoxies of capitalism or socialism and the need to promote culturally acceptable and relevant policies.' (Interaction, 2005)

Local action, global impact

Our argument is that investment in social capital through the mobilisation and involvement of local communities is key to developing ethically based,

sustainable and culturally sensitive mental health services. The three examples below show how this can be achieved, locally, nationally and internationally.

Sharing Voices (Bradford)[3]

Sharing Voices (Bradford) (SVB) is a community development project that focuses on mental health. It works with minority ethnic communities including South Asian, African, African Caribbean and others in Bradford to find alternative and new forms of support for those experiencing distress. It uses community development (CD), premised on the belief that poverty, racism, loneliness, relationship difficulties, domestic violence, sexual abuse and spiritual dilemmas are often at the heart of mental health crises. CD focuses on improving well-being by addressing economic, social and environmental factors, with a commitment to equality and empowerment. It provides an opportunity for people to acquire skills and confidence in devising their own responses to distress. It fosters a sense of ownership of their services and reduced dependency on others. Cohesion and social inclusion are recognised aims of CD (Yasmeen *et al*, 2004).

The project has five staff, including two community development workers, one community engagement worker and a co-ordinator. It works across all black and Asian communities, identifying shared concerns while respecting differences. This resonates deeply in Bradford where communities, even within the majority Pakistani population, have been described as fragmented and suspicious of each other. CD lies at the heart of many activities aimed at building community cohesion in the city following the riots of 1995 and 2001.

SVB aims include:

- to enable people experiencing mental health problems, their families and others to develop sustainable solutions within the community
- liaison with statutory service providers to improve the range and quality of services
- to stimulate a wider debate locally, nationally and internationally about the nature of mental health, diverse perspectives and ethnicity.

The workers have successfully engaged a wide variety of individuals, families and communities, including key gatekeepers and existing voluntary/statutory sector organisations that focus on mental health, and many that work outside the traditionally defined boundaries of 'mental health', such as the countryside services, the Bangladeshi Youth Organisation and youth services. This requires perseverance; much time is spent listening and talking to people in a wide variety of locations, including informal and small local networks, often with no immediately obvious outcome. However over time the workers have successfully developed relationships

built on trust, with an open and honest approach that acknowledges the limitations of mainstream mental health services. This has resulted in the development of several community groups. Many of these are gender and faith specific; some are neither. Hamdard, for example, is run by South Asian women who have experienced distress, and who found a road to recovery in their Islamic faith and peer support. On the other hand, the Creative Expressions group has brought together culturally diverse women, to share their experiences of distress and oppression, and to express this through poetry and painting.

At the time of writing, SVB is nearing the completion of an evaluation by the Sainsbury Centre for Mental Health and the University of East Anglia. This work is now in its final stages, but a preliminary report has already been published (Seebohm *et al*, 2004). The evaluation used participatory action research (PAR) to identify six community groups linked to SVB who were keen to participate in the evaluation. Community volunteers from these groups were trained by the project team in qualitative research methodology, questionnaire and semi-structured interview design, interviewing skills and ethics of research. These researchers then established contact with 126 people in the community from a great variety of backgrounds, all of whom had experienced mental distress and had had contact either with SVB or with the mental health services. The researchers set up focus groups and/or undertook in-depth interviews with their peers.

Evolving Minds[4]

Evolving Minds (EM) is a public forum for alternative approaches to mental health. It meets monthly in a room above a pub in the West Yorkshire town of Hebden Bridge. The meeting was triggered by a public screening of the film Evolving Minds where the director, Mel Gunasena, interviewed a monk, a shaman, a nutritionist and a spiritual psychologist about their different ways of helping someone who has psychotic experiences. Over 70 people turned up to watch the film, following which there was a lively discussion and much interest in taking the discussions further. The ensuing meetings uphold the value that there is no one superior way of understanding our mental health. EM includes personal, political and spiritual perspectives in discussions. The meetings create space for the wisdom of subjective experience, which in western culture is rarely heeded. Consequently, many guest speakers integrate personal experience with other forms of knowledge.

Meetings begin with music, poetry, or storytelling, and this is followed by one or two presentations, with opportunities for small group discussion. Topics have compared eastern and western perspectives on the value

---

[3] salma.yasmeen@sharingvoices.org.uk Sharing Voices Bradford, 99 Manningham Lane, Bradford BD1 3BN

[4] rufus@rufusmay.freeserve.co.uk Rufus May, Bradford Assertive Outreach Team, 48 Ashgrove, Bradford BD7 1BL

of self-esteem, and considered the questions: 'How do we survive living in a mad world?' or 'How does war affect us emotionally?' The aim is to demystify subjects and there is an emphasis on moving away from professional jargon and universal objectivity. EM has also considered 'How to live with suicidal ideas', and the use of dance and movement to deal with low mood. Future topics include shamanic journeying, parenting, coming off psychiatric medication, and peace work at an individual and community level. Some of the relationships forged at EM are resulting in innovative developments with local mental health services. For example, two members have started a recovery initiative on the acute psychiatric admission wards at Lynfield Mount Hospital, Bradford. These are attended by patients and staff.

EM values socio-political approaches to mental health. For example, it has used Forum Theatre – a form of participatory drama in which the audience is invited to re-enact the scene in different ways, to achieve more favourable resolutions of the original dilemma (Boal, 2000) – to respond to experiences of oppression and to protest against the rise of biomedical psychiatry. It stands in polar opposition to the values of globalised biomedical psychiatry; in Britain, a bastion of biomedical psychiatry, it looks in the opposite direction to a broad range of folk and other understandings of madness and healing. By attending the meeting, people from a variety of backgrounds are able to build alternative understandings about how best to deal with and prevent mental health problems. In this sense it encourages communities to consider ways of taking more responsibility for those who suffer or become confused, rather than devolving this entirely to unknown professionals.

PaPA[5]

Policy and Public Action (PaPA) is a new, four-year programme developed by the charity Mental Health International Development (MHID) to enable people with mental health problems and their organisations to engage effectively and creatively in mental health policy issues locally, nationally and internationally. The programme is based on the belief that grassroots communities have a major contribution to play in the bottom-up development of successful and evidence-based policy, and that building their capacities, skills and knowledge can contribute to social development. PaPA uses a bottom-up process in which users, stakeholders and NGOs can create and develop new policy ideas and monitor and evaluate the performance of existing policy and legislation. PaPA embeds the policy-as-process model in all its activities. Public action is collective action such as lobbying, campaigning, direct action and media work to make social change and influence the development of policy.

A core principle of PaPA is that people who experience (or have previously experienced) mental health problems must be at the core of grassroots policy development. This means they should be in a position to have a voice and manage, review and promote policy initiatives directly themselves, not simply through the activities of professionals and other stakeholders. As a consequence, PaPA ensures that at least 33% of participants are (ex)users of mental health services and that all strategic positions are occupied by users. PaPA has emerged from a number of sources, including the evaluation of the Pathways to Policy programme that MHID led between 2001 and 2004. This programme successfully developed local and national policy forums in Eastern Europe, central Asia and India. Other sources include action research data collected by activists and development managers developing public action for mental health. A third is the strategic analysis of the international mental health policy environment undertaken by MHID and by the MIRROR think tank run by the Interaction secretariat. Whereas previous policy programmes have sought to build capacity and networks in local communities, PaPA deploys these capacities and networks to bring about social change. This means more inclusive and supportive communities in which excluded and vulnerable groups have a voice and a way to have their needs and aspirations met. The programme is therefore more ambitious and supports local users and other stakeholders to build more inclusive communities in which people with mental health problems (and their families) are valued, respected and listened to through bottom-up policy initiatives and co-ordinated public action.

Conclusions

Table 2 compares the main features of local knowledge with the dominant global biomedical paradigm. It is important to recognise that 'local' here refers to a diversified reality across the world, with multiple identities and social groups. Globalisation is multi-faceted. Some aspects, such as the world-wide web and internet, have brought benefits for many by democratising access to knowledge and information. Nor would we wish to polarise too acutely the distinction between global and local knowledge. There is much to be gained when those who challenge hegemonic discourses can network trans-nationally. For example it is important that those who challenge and resist universal interpretations of distress know that others in different parts of the world are engaged in the same struggle. Where globalisation tends to homogenise the world, engagement with the grassroots concerns of people in local communities – issues embedded in common social realities and relationships such as gender relationships, family structures, ethnicity, faith and spirituality, age and sexuality – highlights the paradoxes

---

[5] See www.mhid.uk.net (accessed 21st June 2005).

Table 2: Local versus global knowledge in mental health

	Local	Global
Epistemology	Heterogeneous: knowledge is held in the community, in life stories, in personal and community experience, in written and spoken word, in art, poetry and other diverse sources	Universal: knowledge is defined, boundaried and protected by language, terminology, jargon and notions of expertise
Values	Participatory Democratic Social justice Negotiated Sustainable – human relationships, environment Diversity	Oligarchy Un- or pseudo-democratic Global capitalism Marketing Exploitation – human relationships, environment
Economy	Social capital, bartering (eg. LETS (local employment trading schemes) and other alternatives to money) Black or grey economies based on local trust, inter-connections between households Poverty and marginal livelihoods mediate the day-to-day priorities for people	Trans-national capitalism
Interests served	Ordinary people, service users, individuals and groups Families/households Communities	Centralised bureaucracies Global corporations and organisations Governments Professional groups – psychiatry, psychology
Interpretive systems	Religious faith and spirituality Alternative lay belief systems Social and political struggles Political groupings Households and families	Science and biomedicine Psychiatry and psychology Sociology
Understandings of madness	Normal Journey/enlightenment Possession/shaman Spiritual Crisis, risk Inclusion Recovery	Mental illness, risk Exclusion 'Cure'
Accountability	Individual, groups Local communities	Oligarchs and shareholders
Solutions	Local, ecologic, evolutionary small-scale, shared, relevant, individual, involving, meaningful, owned, long-term	Imposed, alienating, mass, standardised, frightening, short-term projects

of diversity. These factors are the ground out of which we individually nurture our understandings of ourselves through our lives.

At the same time we are becoming more aware of our cultural differences. This means that tolerance and respect for diversity are of paramount importance. We believe that ED and EA countries have much to learn from each other by coming together in a democratic debate about the values and philosophy of mental health care. Organisations like the WHO, in fulfilling

their global role, must recognise the importance of plural interpretations of distress that take us beyond a narrow, biomedical approach. This means developing policies with a revitalised ethical focus that emphasise the importance of sustainability and the value of local democratic debates, in which communities, NGOs and governments can set out for themselves how distress is to be understood. Community development is well-suited to enable these debates, and to assist in the articulation of local knowledge.

Finally, our analysis suggests that, in terms of health policy, it is essential that governments in EA countries establish independent reviews (independent, that is, from the interests of professional groups and the pharmaceutical industry) into the future of mental health services. These reviews should be wide ranging and cover the epistemological basis of mental health services, their values and sustainability. There are already moves in this direction in England with the working groups exploring workforce issues in mental health[6] set up by the National Institute for Mental Health in England and professional organisations. Although there are service user and carer representatives, professional elites dominate, so it is difficult to see how the recommendations of such groups will be free from professional interests. The situation with regard to psychiatry is particularly complex. There are difficulties with recruitment and retention, signs of a split between the interests of the majority of non-academic clinicians and those of senior academic clinicians (Bracken & Thomas, 2005, see especially introduction), the burgeoning cost of the profession, and the continuing problem of the relationship between the profession and the pharmaceutical industry. For these reasons we argue that, as a matter of urgency, the government sets up an independent review of the future of the profession. ✪

REFERENCES

XIII World Congress of Psychiatry (2005) http://www.wpa-cairo2005.com/xiii_pres.html (accessed 15 July 2005).

Andreasen N, Black D (2001) *Introductory textbook of psychiatry.* Arlington, VA: American Psychiatric Publishing.

Boal A (2000) *Theatre of the oppressed.* London: Pluto Press.

Bracken P, Thomas P (2001) Postpsychiatry: a new direction for mental health. *British Medical Journal* **322** 724-727.

Bracken P, Thomas P (2005, forthcoming) *Postpsychiatry: mental health in a post-modern world.* Oxford: Oxford University Press.

Fortune (2002a) Pharmaceuticals rank as most profitable industry, again. 'Druggernaut' tops all three measures of profits in new *Fortune* 500 report. Fortune. www.citizen.org/documents/fortune500_2002report.PDF (accessed 5 June 2003).

Fortune (2002b) The Fortune 500: largest US corporations. *Fortune* 15 April. www.fortune.com (accessed 17 September 2002).

Foucault M (1967) *Madness and civilization: a history of insanity in the age of reason.* London: Tavistock.

Higginbotham N, Marsella A (1988) International consultation and the homogenization of psychiatry in Southeast Asia. *Social Science and Medicine* **27** 553-561.

Interaction (2005) *Policy position paper 1: Involving all stakeholders in mental health policy – a challenge for the intergovernmental organisations.* www.interaction.uk.net/pdf/policy_position.pdf (accessed 8 March 2005).

Jenkins R, Cutler P, Hayward R *et al* (2005) The evidence base in policy and practice. In: Knapp M, McDaid D, Mossialos E *et al* (eds) *Mental health policy and practice across Europe.* Buckingham: Open University Press.

McKenzie K, Patel V, Araya R (2004) Learning from low-income countries: mental health. *British Medical Journal* **329** 1138-1140.

MDAC (2003) *Cage beds: inhuman and degrading treatment in four EU accession countries.* Budapest: Mental Disability Advocacy Center. http://www.mdac.info/documents/Cage_Beds.pdf (accessed 20 July 2005).

Moncrieff J (2003) *Is psychiatry for sale? an examination of the influence of the pharmaceutical industry on academic and practical psychiatry.* Maudsley discussion paper. London: Institute of Psychiatry.

Price D, Pollock A, Shaoul J (1999) How the World Trade Organisation is shaping domestic policies in health care. *Lancet* **354** 1889-1991.

Rose N (1986) Psychiatry: the discipline of mental health. In: Miller P, Rose N (eds) *The power of psychiatry.* Cambridge: Polity Press.

Schultz S, Andreasen N (1999) Seminar: schizophrenia. *Lancet* **353** 1425-1430.

Seebohm P, Thomas P, Henderson P *et al* (2004) *Sharing Voices (Bradford). Participatory action research evaluation: early findings.* London: Sainsbury Centre for Mental Health.

Thomas P, Bracken P (2004) Critical psychiatry in practice. *Advances in Psychiatric Treatment* **10** 361-370.

Timimi S (2005) Effect of globalisation on children's mental health. *British Medical Journal* **331** 37-39.

van Ommeren M, Saxena S, Saraceno B (2005) Mental and social health during and after acute emergencies: emerging consensus? *Bulletin of the World Health Organisation* **83** 71-76.

Wanless D (2004) *Securing good health for the whole population.* London: the Stationery Office

World Health Organization (2001) *Atlas: mental health resources in the world 2001.* WHO/NMH/MSD/MDP/01.1. Geneva: WHO.

World Health Organisation (2002) *Mental health global action plan: close the gap, dare to care.* Geneva, WHO. http://www.who.int/mental_health/media/en/265.pdf (accessed 18 February 2005).

World Health Organisation (2005, in press) *Mental health atlas 2005.* Geneva: WHO.

Yasmeen S, Bracken P, Thomas P (2004) Engaging communities: the Sharing Voices initiative. *Mental Health Today* April 31-33.

---

[6] See www.nimhe.org.uk/downloads/WorkforceIssue5.pdf (accessed 15th July 2005).