# A call to review values, commitment, and outlook to mainstream mental health

Mental health cannot succeed within integrated and holistic care solely through the efforts of those who work in mental health. The need to mainstream mental health within global health is thus axiomatic. While there are shifts in this direction, mental health remains mostly an add-on in global health programmes. Layering mental health into global health efforts in low- and middle-income countries (LMICs) is further beset with many challenges related to the neo-colonialist agenda of global health. While the need to decolonise global health is recognised,[1] making this a reality is a formidable task. This is a call for improved terms of engagement to centre mental health more firmly in the global health agenda and enable and encourage the generation of frameworks and theories grounded in contextualised learning from LMICs.

Global health researchers have vigorously engaged with mental health in recent years. This is laudable and in keeping with calls for health systems reforms towards person-centred health care.[2] It is common for mental health tools and metrics to be embedded in priority areas such as infectious disease management; maternal and child health; multimorbidity; vulnerable youth populations; and developing new health technologies. However, it is questionable whether mental health is fully integrated.[3,4] Mental health specialists are commonly only invited to oversee or curate the mental health aspects of the research data and are not necessarily central to the research endeavour.

Additional concerns emerge when these developments are layered into research in LMICs. LMIC mental health specialists are often brought in to contribute local knowledge, with this information then packaged to fit the parameters of well-known epidemiological inquiries or interventional research developed in the Global North.[4] There is little room for the development of Global South mental health leadership and framework development grounded in the contextual realities of LMICs. As such, the transformative goals of global (mental) health are tokenistic,[5] with the underlying bureaucracies, funding, and academic structures having remained unchanged.[6]

Related to the above concern is the proliferation of replicable mental health interventions and "toolkits" by Northern partners to respond to the health problems of the Global South. There are widely commercialised products around psychotherapies, interventions, and training toolkits that are a thriving enterprise within global health. As with frameworks, the testing of these tools developed in the Global North on populations in the Global South is more likely to be funded, leaving little room for the development of locally developed tools and reverse innovation. Further, the adoption of these global mental health interventions and tools by LMICs accords global mental health status and assists with career advancement of global mental health researchers based in the Global North. It also provides a reservoir for feeding the global mental health industry. There are countless examples of training (a new trend being "fidelity" and "adherence training", reductionistic, mechanistic processes of cultural contextualisation) and certification courses provided to local researchers and clinicians in the use of such interventions. This is all in the pursuit of achieving equity in global mental health, papering over the underlying economic and social inequities within and between countries, which are at the root causes of these health inequities.[7,8]

Given this backdrop, there is an urgent need within the global mental health project to engage authentically with the localities that it purports to serve. Within a decolonising and person- centred frame, contextual psychosocial and socioeconomic realities should take centre stage in the identification, definition, and prioritisation of mental health needs (including grassroot appraisal of risk and protective factors). Both funders and academics based in the Global North should take note of the critical importance of context and empowerment—mental health researchers from LMICs are experts in what their communities need. Defining problems and proposing solutions that simply add mental health to existing disease control narratives is naïve at best, and lip-service at worst. We know that country-level investment in human resources and public mental health infrastructure needs improvement; the responsibility of national

***Panel:* Opportunities to create a better world via a liberatory global mental health field**

1 Social media and international development agencies are making the connection between peace, health, the environment, and happiness. Yet the current openness and embracing of a "mental health responsive" world must be equity-driven.
2 Southern partners need to develop global mental health training programmes that provide guidance, training, and frames of reference for HIC researchers and students, with the active support of funders.
3 With improved recognition of the voices and perspectives of individuals with lived experience and individuals living with adversities, the lived experience of practice and advocacy of researchers and clinicians in LMICs need to be similarly valued.
4 There is an increased recognition that mental health is a human right and a global good which needs strengthening across the world and within countries in all sectors of programming.[9] The recognition of integrated programming can help in formulating questions that target mental debilities that emanate due to poor social conditions.[10] In-country mental health researchers are the leaders here and point to persistent and understudied mechanisms.
5 Funders are willing to invest in mental health more than ever before and governments are talking about self care and behavioural risks in addressing population-level health and development. In taking advantage of these changes, we need to draw contextual lessons from system leaders and grassroot workers. We do not need more global think tanks or advisers from the Global North.
6 Political mobilisation cannot become a new arena of interest for global health actors without participation of local actors studying the contextual local burden of mental disorders and regional cross-sectoral actors.[10]

policy makers is no less important in shaping global and national mental health discourses. Authentic engagement requires that the lived experiences of people in LMICs—community members, service users, but also academics, health workers and policy makers—become the first step in scoping global mental health projects (panel). The transference of theoretical notions and frameworks of integrated care, based on high-income-country health-system structures, has a neocolonial undercurrent, and disregards the critical importance of local understandings of mental ill-health and its management.[9] Ultimately, global mental health engagements between North and South partners should be built on the principles of epistemic justice (fairness in knowledge, understanding, and participation in research and practice); pragmatic solidarity (tangible and material solidarity that moves beyond a charity-like solidarity by empowering the vulnerable); and sovereign acts (capacity to engage with specific contexts in a way that enables the creation of spaces of care, safety, and value)—key pillars in developing equitable, effective and just mental health systems.

We declare no competing interests.



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