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An independent academic psychologist, based in England, who has written extensively on different areas of psychology with an emphasis on the critical stance towards traditional ideas.

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1. PUBLIC MENTAL HEALTH ETHICS

1.1. INTRODUCTION

Silva et al (2018) began: "The burdens of mental illnesses and substance use disorders do not lie merely with the individuals who suffer from these conditions but affect, and are affected by, their families, communities, cities and countries. The ethical and political challenges that arise in the treatment of mental illnesses and substance abuse disorders are, therefore, challenges that affect both individuals and communities" (p121).

"Public mental health ethics" (PMHE) covers such challenges, including the promotion of mental health in populations, and the prevention and treatment of mental and substance use disorders in populations (Silva et al 2018).

The burden of disease is an ethical issue because people living with severe mental and substance use disorders have a significantly shorter life expectancy than the average, face stigma and discrimination, and are disadvantaged in terms of poverty more often (Silva et al 2018).

The public policy response to mental and substance use disorders in the population also needs ethical scrutiny. At the extreme, for example, President Duterte in the Philippines in the 2010s declared a "war on drugs" (which was in some cases literal with police shootings of suspected drug users, and human rights violations) (Silva et al 2018). A more everyday example with substance use could be whether to provide safe injection drug sites. Meanwhile equitable and universal access to mental health care is a United Nations goal (Silva et al 2018).

Introducing a special issue of the journal "Public Health Ethics" on PMHE, Silva et al (2018) noted three themes:

i) Understanding the concepts.

ii) Balancing the interests of the individuals with mental and substance use disorders with those of the public health system as a whole.

iii) What "prevention" means in psychiatry.

1.2. TASK SHIFTING

"Unintentional poisoning from drugs such as oxycodone, fentanyl analogues, and heroin is now a global health crisis, accounting for hundreds of thousands of annual deaths worldwide" (Buchman et al 2018 p151). This "epidemic" is the consequence of a number of factors including opioid over-prescribing, and marketing strategies by pharmaceutical companies, and includes "the systemic marginalisation of people at risk of overdose" (Buchman et al 2018 p152). This is seen most starkly in many countries where contacting emergency medical services for an overdose also leads to law enforcement personnel being informed. "People who used drugs were left with an untenable, unnecessary and often deadly decision. Accessing essential emergency healthcare often resulted in arrest" (Buchman et al 2018 p152).

One response to this situation in the USA has been the "Overdose Education and Naloxone Distribution" (OEND) programmes, where the opioid antidote naloxone is distributed at needle and syringe distribution centres as well as education about essential resuscitative care. Buchman et al (2018) argued that such programmes have shifted responsibility for overdose response to individuals and away from health care services. This is "task shifting".

Task shifting in health generally can be beneficial in that lay people provide services where health professionals are not available, say (eg: Sub-Saharan Africa and HIV). "The ethics of task shifting has received scant attention in public health and bioethics. Most of the task shifting scholarship that raises ethical issues come from the HIV/AIDS literature. The literature reports ethical issues such as a potential decrease in quality of care when medical interventions are delivered by non-physician clinicians or lay workers...; how task shifting can increase access to HIV/AIDS treatment for structurally vulnerable populations in resource-limited settings; the potential financial exploitation of workers; and how policy inaction to expand task shifting for HIV/AIDS treatment amounts to indefensible healthcare rationing" (Buchman et al 2018 p154).

But task shifting with OEND programmes does not reduce the inequities that overdose-risk individuals face; in fact it may increase them (Silva et al 2013). Stigma and illegality worsen the situation for drug users.

Silva et al (2013) outlined three ways in which public health policies and practices unintentionally worsened disadvantage of already disadvantaged populations:

i) Apparently objective evidence has a subjective side - eg: moral views of policymakers underpin opposition to harm reduction policies rather than scientific evidence, or the appropriate studies are not performed to provide the evidence.

Though evidence is important, at the same time, Buchman et al (2018) argued that "the success and effectiveness of OEND should not be defined in solely scientific or ostensibly objective terms but also normatively and relationally. Objective data cannot be disentangled from the social, political and historical contexts from which they emerge... Furthermore, since people are at the centre of public health practice, the effectiveness of OEND programmes should also identify and address the preferences of the affected communities" (p156).

ii) The tension between utilitarianism (the greatest benefit for the greatest number) and social justice (the reduction of inequalities) in policymaking - Powers and Faden (2008), for example, proposed the idea of "sufficientarianism" - ie: "the most disadvantaged populations and sub-populations in society should be brought above a certain threshold of well-being. On their account, ensuring that multiply disadvantaged social groups receive a sufficient amount of each of the essential elements of well-being will improve health and well-being for all... For example, if focusing government funding on reversing opioid poisonings and saving lives is a critical goal for public health policy, this focus should not distract from correcting other structural concerns that systematically sustain people who use drugs below a sufficient threshold of well-being, which includes inequity in health. Additional structural issues include inadequate and unstable housing, violence, poverty, as well as punitive drugs laws and policies, and the stigmatisation of people who use drugs" (Buchman et al 2018 p157).

iii) Public health workers do not necessarily understand the lived experience of marginalised populations - A public health policy, for instance, may be based on going to a clinic for help, but a drug user may not want (or be able) to contact "authorities" as they see it through fear of legal consequences.

Buchman et al (2018) ended: "We argued that public health practitioners must consider the social and ethical aspects of task shifting that may lead to reduced fatal opioid poisonings but fail to improve access to healthcare. This process may do little to decrease structural vulnerability and may increase it if people who use drugs retreat further from healthcare settings. From a social justice perspective, we believe that even if OEND programmes reduce opioid-related morbidity and mortality, their necessary existence may have the paradoxical and inadvertent effect of disenfranchising structurally vulnerable populations from healthcare services, including mainstream emergency care" (p159).

1.3. SAFETY AND RISK

"Safety" and "risk" are "key public health problems in mental health" (p165), but they are "differently articulated as a result of the different interests underpinning these terms — what is understood as 'safe' for one set of actors, may compete with, or be understood differently for, others" (Smith-Merry 2018 p165). This has led to an "ethical balancing act" (Snow and Austin 2009) for policymakers and service providers.

Safety and risk relate to the individual themselves (eg: suicide) and to others. Firstly, individuals "have a need to feel safe when they are mentally unwell and to be protected from self-harm and suicide" (Smith-Merry 2018 p167). This includes how the individual is treated in care as well as the use of compulsory treatment and detainment orders. "It is important that health consumers are able to speak up when they feel that their care has been compromised and that their accounts are given credence" (Smith-Merry 2018 p167).

The safety of others includes carers and family members, healthcare workers, and the general public. "Carers and family members of someone experiencing mental ill-health have both an interest in their own safety and in the safety of those who they care for. Carers informally manage risk to the consumers they care for within their own homes and communities on a daily basis, but are not routinely involved in discussions with services. Safety of both consumers and carers is often compromised when carers are not kept informed or included in discussions about treatment, including discharge" (Smith-Merry 2018 p168).

Healthcare services usually have risk assessment systems. "Risk assessment practices are based either on actuarial risk assessment tools or on broader state or territory guidelines and involve balancing the competing safety needs of staff, consumers and the public... Actuarial systems of risk determination involve a risk matrix which can be used to understand those most at risk of violence to the public" (Smith-Merry 2018 p169).

The risk to the general public is also influenced by media reporting, which can conflate mental illness with danger and increase the perceived risk. An upshot is stigma and discrimination for mental illness sufferers.

Smith-Merry (2018) argued for shared understandings of safety, which "will mean that the safety needs of relevant actors can be understood and negotiated rather than giving way to an actuarial process which does not take into consideration the context of a person's life" (p165).

1.4. PREVENTION

Prevention of future illness is very important in the field of public health, but Radden (2018) argued that prevention is "an ambiguous and complicated category when applied to mental and behavioural health" (p126).

Radden (2018) outlined a number of relevant issues:

i) Prevention versus treatment - "Prevention addresses events or states that have not yet occurred; treatment those that have, when these states or events correspond to the occurrence or presence of diagnosable disorder. Vagaries surrounding diagnosis, so notable with mental ill-health due to its lack of unequivocal verifiability, complicate when prevention ends, and treatment begins, in this arena. First, the outset of disease is rarely easily or conclusively determined with mental disorders, which typically shade into normal states, often anticipated (and afterward trailed) by symptom-like phenomena" (Radden 2018 p127). Mental disorders can be episodic rather than continuous, which adds extra complexities.

ii) At what age to introduce preventive interventions? For example, if it is very young, there is the issue of the ability to give consent.

iii) The allocation of resources for preventive strategies compared to for treatment - Resource allocation should be based on evidence, but decisions "must be determined under conditions of significant uncertainty in the mental health arena, where full knowledge is still wanting over (i) the nature and course of the disorders involved; (ii) many aspects of their causes; (iii) specific preventive elements involved in interventions; and (iv) the long-term and unintended consequences of such interventions" (Radden 2018 p129).

iv) The ethics of different preventive strategies - Universal programmes, for example, are aimed at everybody irrelevant of an individual's risk, and often are undertaken at schools. "Such initiatives will always require scrutiny of their substance... Like all educational campaigns, they must adhere to the strictures governing informative and exhortative communications — avoiding misinformation, intimidation and coercion. Raising awareness about depression and suicide in school curricula illustrates some of the particular ethical pitfalls associated with such pedagogies: a failure to distinguish the difference between correlations and causes that often suggests that depression and suicide are more causally linked than available data warrants; no room for discussion of the possibility of rational suicide...; admonitions adopted without discussion of their costs in privacy, loyalty and confidentiality; uncritical acceptance of medical conceptions of disorder that include biological reductionism and unqualified parallelism between mental and physical disorders; and employing scare tactics in describing the consequences of untreated disorder" (Radden 2018 p131).

Selective preventive programmes focus upon high-risk individuals, and there is the potential stigma of being enrolled in such programmes, for instance. "Stigma about mental disorder includes negative stereotypes, the resultant negative emotional reactions flowing from those stereotypes and discriminatory behavioural responses. The consequences of this stigma are found in self-stigma, where those with mental illness internalise negative stereotypes, as well as in public attitudes and structural discriminations that intentionally or unintentionally disadvantage those diagnosed with mental illness... Such consequences are known to adversely affect the use of mental health-care services and help-seeking behaviour" (Radden 2018 pp131-132).

Terms like "prodrome" are used for high-risk individuals, and the language chosen is important. Are the individuals "already on the path to" a disorder, and is it inevitable without help? In the case of psychosis, "non-converters" (ie: individuals with early symptoms that do not convert to psychosis or "false positives") can be up to half in longitudinal studies (Radden 2018).

Radden (2018) ended: "Ambiguities surround the concept of prevention when it is employed in contemporary initiatives involving public mental health, raising far-reaching ethical issues about the proper role of science and government, and who should be the arbiters of health norms. With the advent of policy to employ preventive approaches for public mental health, these considerations require close scrutiny" (p133).

It is important, for Waddell et al (2018), that policymakers recognise that mental health problems start in childhood, and "[W]aiting until adulthood to intervene has not sufficed and will not suffice" (p196).

Waddell et al (2018) argued that "children's mental health remains underappreciated as a public policy priority, to a degree that violates children's rights" (p191). These authors outlined "three central public health ethical challenges" to be resolved: "(i) addressing the high prevalence and impact of childhood mental disorders; (ii) addressing the avoidable social adversities that underlie many childhood mental disorders; and (iii) addressing stark shortfalls in prevention and treatment services for children" (Waddell et al 2018 p191).

1.5. SUICIDE PREVENTION

The ethics of suicide prevention tend to be concerned with "the use of coercive, invasive or emergency interventions and their implications with regard to the rights, interests, values, dignity and capacity of persons who are suicidal" (Fitzpatrick 2018 p179). These are focused at the individual level. "This emphasis on the individual works to responsibilise individuals and communities for suicide prevention and directs attention away from public policy and systemic inequities. Given continued high rates of suicide, especially among disadvantaged social groups and communities, comprehensive government action is required to address the social and political determinants of suicide", argued Fitzpatrick (2018 p179). For example, an awareness by governments of their non-health-related policies and programmes and the social determinants of suicide, like farmer suicide in India, which was linked to debt and alternative employment opportunities, for instance, or state intervention in the wine industry in Australia and wine grape growers (Fitzpatrick 2018). In the latter case, there were perceived injustices which were "the potential basis for distress, but also for expressions of moral outrage at the violation of loyalty, trust and respect in social and economic relations between grape growers, wineries and the state. The connection between farmer distress and emotions such as anger and contempt exemplifies cognitive and cultural conceptualisations of emotion in which beliefs and moral judgements have a central role... Emotions of shame and guilt were common to farmers' experiences of distress and closely bound with perceptions of self-worth and attributions of personal responsibility" (Fitzpatrick 2018 pp184-185). An individual-focused approach to suicide prevention can only have limited value in this situation.

The concept of "structural violence" can be used as "a means for articulating the often pernicious structural processes that impact upon human lives and that are so complex, multi-layered and diffuse as to make ascriptions of responsibility difficult... Because the concept of structural violence emphasises the systematic inequalities that impact mental health, it offers an opportunity to change the prevailing moral and political discourse of suicide prevention to focus on important issues of rights and justice" (Fitzpatrick 2018 p185).

In summary, Fitzpatrick (2018) argued for a "health lens" on all government policies.

1.6. LIVING WELL WITH DEMENTIA

"Justice requires that public policy improve the lives of disadvantaged members of society. Dementia is a source of disadvantage, and a growing global public health challenge" (Austin 2018 p139). Dementia includes a number of disadvantages; related to older age, disability, and cognitive impairment, as well as the possibility of poverty and abuse (Austin 2018).

"Living well with dementia" is a way to find social justice for people with dementia, argued Austin (2018).

But what does "living well" mean here? Austin (2018) undertook discussion groups and interviews with fifteen policy-makers, practitioners, and academics in the field in the UK in July 2015.

One theme of importance that emerged was "affiliation". One interviewee talked of "that feeling of remaining connected to other people" (p144). As well as relationships with family and friends, there are more generally interactions of what has been called "dementia-friendly communities". As one interviewee described: "the bus driver's going to be kind, if people around her in the shop or wherever will know her and know where to send her back to..." (p145).

"In practical terms, supporting the social relationships of people with dementia sustains and promotes secure functioning in multiple domains, and enables people to live well with dementia together. As well as close personal relationships, the weak ties of affiliation — for example, patient and understanding service workers, and passersby who are willing to help — enable a person with dementia to participate in the life of her community, and are part of the social bases of self-respect" (Austin 2018 p148). Social justice will be seen in public policies that encourage affiliation and in turn "living well with dementia".

1.7. BIG TECH AND MEDICINE

"Large consumer technology corporations are becoming increasingly influential in health and medicine. While this is sometimes beneficial to public health, it also raises many risks, like inequitable returns to the public sector in public-private medical partnerships or new dependencies on technology firms for the provision of public health goods and services" (Kraaijeveld and Sharon 2025 p1).

"Big Tech" (eg: Amazon, Apple, Meta) has become involved in areas of health and medicine like home medical surveillance, electronic health records, digital biomarkers, and predictive measures for outbreaks of infections, as well as the field of telemedicine, mHealth, and eHealth (Kraaijeveld and Sharon 2025).

The phrase "'Googlisation' of health" has been used (Kraaijeveld and Sharon 2025). It is an example of "sphere transgressions" (eg: Stevens et al 2024), which asserts that "the increased digitalisation of various societal spheres — such as health, education and law — invites new actors into spheres where they have not traditionally operated. These actors own the software and the hardware needed for digitalisation and possess the relevant digital know-how and expertise, but they may not always share or heed, let alone promote, the core values of the spheres in which they come to operate" (Kraaijeveld and Sharon 2025 p1). Risks include, Kraaijeveld and Sharon (2025) argued, "undue influence on medical research agendas by private actors who are not domain experts; inequitable returns to the public sector in public-private medical partnerships; new dependencies on technology firms for the provision of public (health) goods and services; and a reshaping of the spheres of health and medicine in line with corporate values" (p2).

The increasing influence of Big Tech in health and medicine can be seen as a "public problem" (Dewey 2016) - ie: "it raises the prospect of harms that are experienced collectively, if not individually" (Kraaijeveld and Sharon 2025 p2). For example, at the population or collective level, Big Tech's (and associated philanthropists) interests in certain areas of health "can distort funding landscapes by funnelling attention and resources to specific areas of interest (ie: those about which philanthropists are concerned) while drawing goods away from other important areas of need... It cannot and must not be assumed that the (re)direction and (re)distribution of resources along the interests of powerful individual actors and corporations is straightforwardly good for public health. Even if the private and corporate distribution of health services may sometimes serve public health, personal and corporate interests may clearly also be unaligned with — and even directly opposed to — pressing public health needs" (Kraaijeveld and Sharon 2025 p3).

Big Tech corporations are large in some cases and outdo smaller governments in certain situations. This is not a problem when both parties are working together for public health, but what happens when there is conflict? For example, a growing dependency on Big Tech can have risks. "It is misleading to see the health and medical services of these corporations as stand-alone products; they are almost always part of a broader 'suite' of hardware, software, apps, clouds and operating systems. Using any one of these services generally implies buying into an entire ecosystem in which products from other providers cannot function, thus creating technological lock-in" (Kraaijeveld and Sharon 2025 p6).

Much of the interest in technology and health has been practical, and ethical concerns have been regulated, ended Kraaijeveld and Sharon (2025), but there needs to be "ongoing discussions about what constitutes and serves good public health in the age of Big Tech" (p6).

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2. DIRECT-TO-CONSUMER ADVERTISING OF PRESCRIPTION DRUGS

Direct-to-consumer (DTC) advertisements for prescription drugs are "a fixture of the American media environment" (Kravitz 2026 p1.2) for many years. These are "product claims advertisements" [1], which include the brand name and an approved clinical condition of use, as opposed to "reminder advertisements" (product name only), and "disease-awareness or help-seeking advertisements" (clinical condition only) (Kravitz 2026).

Kravitz (2026) concentrated on the first type in a review of the impact: "DTC advertising is controversial. Proponents argue that DTC advertising educates patients, alerting them to the availability of medically important treatments and encouraging deeper engagement with care. Sceptics counter that such ads stimulate demand for drugs of modest benefit, encourage inappropriate prescribing, divert attention from more pressing medical matters, and degrade the clinician-patient relationship. Opinion polls show that the public views DTC advertising in a neutral-to-positive manner, whereas clinicians lean neutral-to-negative" (p1.2).

Large sums are spend on advertising by pharmaceutical companies, which, it is argued, could be more appropriate as cheaper drugs, while there are concerns about "boundary testing". Ads are meant to present a "fair balance" of benefits and risks, but "advertisers rarely state how well drugs work, and they employ clever devices (including word choice, font size, background, dramatisation, and music) to highlight benefits and minimise harms" (Kravitz 2026 p1.2). While, for example, a study of 199 print ads and 361 TV ads for cholesterol-lowering medications found the downplaying of evidence-based lifestyle interventions to reduce cholesterol (Byrne et al 2013). Other studies have found the use of positive emotional appeals, a lack of quantitative information about risks or risk information read quickly, suggestions of "off-label uses", storytelling and distraction techniques of film-making. "Manufacturers' adherence to the FDA's [US Food and Drug Administration] fair balance requirements might be summarised as generally attentive to the letter of the law but too often dismissive of the spirit" (Kravitz 2026 p1.6).

Which drugs are advertised is another issue. The top

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[1] This type of advertisement is permitted only in the USA and New Zealand (Kravitz 2026).

ten most advertised drugs based on broadcast advertising expenditure in 2016 included "four lifestyle or prevention products, three treatments for common chronic diseases, and three biologic agents for treatment of less common but serious conditions. By 2024, the list's centre of gravity shifted toward biologics, with the top three slots going to risankizumab [for psoriasis or inflammatory bowel disease (IBD)], upadacitinib (for inflammatory arthritis and IBD), and dupilumab (for refractory eczema or asthma), and the rest distributed among newer drugs for diabetes, obesity, asthma, and mental health conditions" (Kravitz 2026 pp1.3-1.4).

The Internet has changed the situation in recent years with social media influencers and Internet personalities advocating medications (eg: Kim Kardashian and the morning sickness drug "Dielegis") (Kravitz 2026). Another change is the "DTC platform" (eg: Eli Lilly), which permits patients to seamlessly access a physician evaluation (usually by telehealth), a prescription, and delivery of the drug by direct mail. In this novel convergence of DTC advertising and telehealth, drug companies are skirting the 'middleman', defined to include not just pharmacy benefits managers and retail pharmacies but also patients' own physicians" (Kravitz 2026 p1.4).

The consequences of DTC advertising can be assessed under four headings (Kravitz 2026):

i) Patients - Put simply, increased awareness of medications, and increased requests for advertised drugs (eg: DeFrank et al 2020).

ii) Prescribing - The "learned intermediaries" (physicians) feeling "pressured to prescribe a drug that would not have otherwise been their first choice" (Kravitz 2026 p1.7). Kravitz et al (2005) performed an experiment where "standardised patients" with major depression visited physicians and asked for an advertised drug or just described their symptoms. The former was over 20% more likely to receive the (clinically appropriate) advertised drug (Kravitz 2026).

iii) Physician-patient relationship - "The effects of DTC advertising on the physician-patient relationship depend on whom you ask and on the outcome of the request. Opinion polls cast patients as relatively sanguine about the effects of DTC advertising on the physician-patient relationship; however, some studies show that unfulfilled requests markedly depress patient satisfaction, and up to 15% of patients whose requests are denied subsequently switch (or plan to switch) doctors. As for physicians, survey and focus group studies have raised concerns about clinical distraction (negotiating about a drug request rather than focusing on diagnostic and therapeutic decision-making), longer visit times, and provision of sub-optimal therapy" (Kravitz 2026 p1.8).

iv) Population level - Increased pharmaceutical expenditures (appendix 2A), and the potential to improve population health. But it depends who responds to the ads (eg: statins and younger individuals who benefit least).

In assessing the benefits and harms of DTC advertising, three lines of analysis have been used - normative, empirical, and reasoned (logic-based) (Kravitz 2026). Normative analysis focuses on the fact that product claims advertising is not permitted in most countries around the world, and the reasons why. An empirical analysis is based on studies of the impact of DTC advertising on the physician-patient relationship and quality of prescribing (eg: risk of prescription of advertised drug for inappropriate conditions; Kravitz et al 2005). Kravitz and Bell (2007) used a reasoned approach - ie: maximise public health benefits and minimise harms. "In short, the benefits of DTC advertising are maximised when the advertised condition is serious, the condition is under-treated in the population, and the treatment is both highly efficacious and safe compared with its alternatives. In contrast, net harms are likely to occur when the condition is trivial, the condition is over-treated, and the treatment is relatively ineffective, unsafe, or both. An example of a DTC advertising campaign that could improve public health is one that promoted the use of one or more first-line anti-hypertensive medications" (Kravitz 2026 p1.9).

Kravitz (2026) made a number of suggestions for policymakers, authorities, and future research. For example, stricter surveillance of ads, particularly on the Internet by authorities (which requires government funding), more complete data on advertisement volume and impact, and selective prohibitions or controls (eg: a medication cannot be advertised until two years after official approval of use).

Kravitz (2026) ended: "Its many problems notwithstanding,DTC advertising can increase prescribing among patients who are likely to benefit from the advertised drug. However, in its current form,DTC advertising is at least as likely to promote medication overuse. Furthermore, many DTC ads accentuate the positive aspects of promoted drugs while underplaying the negative aspects, sometimes in ways that are not readily noticed by consumers. In addition, DTC advertising comes with externalities, such as increased demands on physicians" (p1.14).

APPENDIX 2A - NEW DRUGS

Because of limited funding, there will be a trade-off between paying for new drugs and for older medications and alternative treatments. "New drugs typically have a small evidence base supporting their use upon regulatory approval worldwide. Despite uncertainties in the evidence base, new drugs typically have higher prices than existing options within health-care systems. This combination of uncertain clinical effectiveness and higher prices has historically resulted in substantial regional and global variation in funding decisions and patient access to new drugs" (Naci et al 2025 p50). This is an issue for the National Health Service (NHS) in England, which is guided by the National Institute for Health and Care Excellence (NICE).

Naci et al (2025) reviewed the evidence for benefits and value for money for new drugs recommended by NICE between 2000 and 2020. Information about 332 unique pharmaceuticals were found. The researchers used certain concepts to evaluate the medications, including "incremental cost-effectiveness ratio" (ICER) ("the additional cost required to achieve an additional unit of health outcome with a new treatment, compared with an alternative"; Naci et al 2025 p52), "quality-adjusted life years" (QALYs) ("A health-outcome measure that combines the effects of improvements in both the quantity and quality of life associated with a treatment"; Naci et al 2025 p52).

It was calculated that new drugs generated an estimated 3.75 million additional QALYs for 19.82 million patients, but if that money had been spent on existing services, an estimated five million additional QALYs would have been generated for the whole NHS population of England. So, the overall impact of new drugs was negative for population health as a whole.

The study involved estimated of health costs and benefits, though QALYs, for instance, is commonly used. There was no information around the decisions to recommend new drugs (eg: quantity of evidence of greater effectiveness than older medications), and which areas of health involved (eg: cancer drugs).

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3. MENTAL DISORDERS AND PHYSICAL DISEASES

3.1. OXIDATIVE STRESS-INDUCED DAMAGE

Individuals with psychiatric illness have a higher risk of age-related diseases and mortality than those without psychiatric illness. The "underlying biological mechanisms are not known" (Jorgensen et al 2024 p516).

One possible explanation is oxidative stress-induced damage to nucleic acids (RNA and DNA) (NA-OXS). "Oxidative stress occurs when levels of reactive oxygen species, which are mainly formed during mitochondrial respiration, exceed the anti-oxidant potential of a biological system and cause oxidative damage to proteins, lipids, and nucleic acids, among others" (Jorgensen et al 2024 p517). It is a molecular driver of ageing. This damage is increased in individuals with psychiatric illness compared to controls, according to a meta-analysis by Jorgensen et al (2022).

Jorgensen et al (2024) investigated the relationship between NA-OXS and mortality among individuals with psychiatric illness using Danish data. Two samples with a total of over 7700 adults were used: the Vejle Diabetes Biobank, and the Danish General Suburban Population Study. NA-OXS was measured from urine samples, and psychiatric illness, and mortality rates came from official records.

Overall, 40% of the participants had a history of psychiatric illness, and this group had significantly higher NA-OXS than the non-psychiatric group. During the follow-up period of up to sixteen years, 16.6% of the psychiatric group had died compared to 10.8% of the non-psychiatric group. All-cause mortality increased with NA-OXS in both groups.

Because the NA-OXS was higher with the psychiatric illness group, it was almost as if they experienced "accelerated ageing", and this explained the increased age-related diseases and mortality. But the study was observational (ie: correlational), so causality could not be established.

3.2. CHILDHOOD PSYCHO-SOCIAL ADJUSTMENT

Birth cohorts allow the study of health and behaviour over long periods of time. Two such cohorts in the UK have been running for a long time - the 1958 National Child Development Study (NCDS) (data collected at 55 years old most recent of eight waves), and the 1970 British Cohort Study (BCS70) (nine waves of data collection up to 46 years old).

Liu et al (2024) analysed the data from these two cohorts for midlife hypertension, diabetes, and obesity (cardio-metabolic diseases; CMDs) based on childhood psycho-social adjustment. "Childhood psycho-social adjustment (CPA) encompasses the development of social and emotional competencies that enable children to effectively manage their relationships with peers, family and others in their surroundings. Typically assessed in familial and educational settings, CPA is a multi-faceted construct that includes both internalising behaviours, such as anxiety and depression, and externalising behaviours, such as aggression and hyperactivity. The development of CPAs is shaped by a complex interplay of genetic predispositions, family dynamics, parenting practices and peer interactions. Poor CPA has been associated with elevated adverse cardiovascular biomarkers and premature mortality" (Liu et al 2024 p563). CPA data at 10-11 years old were available (eg: the mother-completed "Rutter Child Behaviour Scale" in the BCS70).

In total there were nearly 27 000 participants. In both cohorts worse CPA was associated with increased risk of hypertension, diabetes, and obesity in midlife. "Specifically, emotional problems, hyperactivity and miscellaneous CPA sub-types were linked to all three CMDs, while conduct problems correlated with hypertension and diabetes. Additionally, mediation analysis suggested that both lower educational attainment and early-life depression partially contributed to the connection between CPA and CMDs" (Liu et al 2024 p568).

In terms of potential mechanisms of the relationship between CPA and CMDs, lower educational attainment was key. "Education, a precursor to socio-economic factors such as occupation and income, is crucial for maintaining healthy lifestyles and accessing healthcare. Individuals with lower educational attainment may be more likely to occupy jobs that are physically demanding, low-paid and offer little control, which are stressors that have been linked to poor health outcomes. Limited income also restricts access to healthcare, nutritious food and safe living environments, further heightening the risk of CMDs. Furthermore, individuals with lower educational levels are more likely to smoke, have poor diets and lead sedentary lifestyles, and they are also less likely to follow medical advice, which diminishes the effectiveness of CMD prevention measures in primary and secondary care, leaving them more susceptible to these diseases” (Liu et al 2024 p568).

3.3. REFERENCES

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4. GLOBAL MENTAL HEALTH

4.1. INTRODUCTION

"Global Mental Health" (GMH) is a field that can be conceptualised as "a global assemblage of diverse and sometimes contrasting ideas and practices, encompassing concepts such as constellations of care, research, and policy" (Bayetti et al 2023 p606). It is associated with the "Movement for Global Mental Health" (MGMH), which is "a social movement and response by the international civil society to particular psycho-medical constructions of mental disorder as a global crisis" (Bayetti et al 2023 p606).

A key concept is the "treatment gap" (Mills 2018) or the "mental health care gap" (Patel et al 2018) between the rich countries and the rest of the world, and between physical and mental health in all countries, which Funk and Van Ommeron (2010) called a "hidden emergency", and Kleinman (2009) a "failure of humanity" (appendix 4A).

The solution is "scaling up" access to mental health care, which Mills and White (2017) described as "the process of increasing the number of people receiving services; increasing the range of services offered; ensuring these services are evidence-based, using models of service delivery that have been found to be effective in similar contexts; and sustaining these services through effective policy, implementation and financing" (quoted in Bayetti et al 2023).

Bayetti et al (2023) reflected on what "scaling up" means in practice. They observed that GMH "prioritises the scaling up of 'evidence-based interventions', justified as a strategy to spur governmental action and resourcing, despite critiques of the applicability and validity of evidence-based medicine (EBM) to the treatment of mental ill health... As a result, treatments whose efficacy is most easily demonstrated using EBM-favoured research methodologies... are largely selected for scaling up. These treatments, including pharmacological and manualised psychological therapies, are perceived to be more efficient, cost-effective, of better quality and with more predictable outcomes" (Bayetti et al 2023 p603). Implicit here is the idea of a "'global' problem" and "a universal solution" (Bayetti et al 2023).

This can mean that "local values" are downplayed or ignored. "People with psycho-social disability" (PPSD) (the preferred terms to mental disorders) around the world do not necessarily seek formal mental health care and/or EBM. "While stigma may partly explain this, so might the emphasis on the biomedical nature of mental illness and treatment often found in psychiatric services. Indeed, the latter often lacks cultural congruence and fails to address the complex nature of the suffering and needs faced by most PPSD..., resulting in waning attendance, increased 'revolving door' patients, and poor treatment outcomes" (Bayetti et al 2023 p604). GMH has an "inherently neoliberal worldview", argued Bayetti et al (2023).

Bayetti et al (2023) favoured a shift from "how can we treat people" to "how can systems support people to live a meaningful and socially included life". "This proposed reframing offers greater intersectionality in what shapes distress and how to address suffering, which invites a broader reconceptualisation of mental health care as more than the absence of symptoms, but rather as dependent on complex systems involving wider social and structural determinants" (Bayetti et al 2023 p604).

Concentrating on the construction of knowledge, Bemme (2023) used ethnographic fieldwork with GMH experts to explore what "mental health" meant in the field of GMH. Initially, the "treatment gap" and "scaling up" based on universal (Western-based) categories was the dominant view in GMH (2007 to 2015). Subsequently, "contingent universality" has emerged, argued Bemme (2023).

Contingent universality is "the temporary stabilisation of facts and artefacts through alignment with the polyphonic priorities of increasingly diverse stakeholders in GMH, at times only for the duration of a project, funding cycle or policy agenda before moving to the next iteration" (p393). What this idea shows is that knowledge is flexible and changeable. "GMH knowledge achieves both global reach and local relevance precisely because 'mental health' can be many things; it can be expressed in a wide range of idioms and concepts, and its problems and solutions align easily with others, at many scales" (Bemme 2023 p385).

Bemme (2023) continued with the argument that "GMH advocates and critical observers alike have created conceptual and practical middle-grounds between different forms of mental health knowledge – across culture, epistemic power, lived experience, policy platforms and academic disciplines – framing their dynamic encounters as dialogue, adaptation, participation, co-production or integration... [So] GMH today is focusing less on establishing mental health as a universal problem than on managing its inherent multiplicity through alignment and integration across different bodies of knowledge" (p385).

The inequity in the global mental health research workforce was discussed by Rose-Clarke (2023) (on behalf of "The Women in Global Mental Health Research Group"), who argued for gender equity with three main arguments that are applicable to any form of inequity:

i) The "global mental health's commitment to a human rights-based approach is undermined by the gender-based discrimination in its research workforce" (Rose-Clarke 2023 p403).

ii) Diversity of experience and perspective improves research quality.

iii) The under-representation of women challenges the relevancy of research. "A more equitable research team will pose more relevant questions and devise more acceptable interventions" (Rose-Clarke 2023 p404).

4.2. WESTERN PSYCHIATRY APPLIED ELSEWHERE

The "Edinburgh Post-natal Depression Scale" (EPDS) (Cox et al 1987) is commonly used to measure depression in mothers in the year following delivery. It was developed in the West, and so there are questions about its applicability elsewhere.

Mutiso et al (2023) investigated this question with Kamba women in Kenya with a local version of the EPDS. Over five hundred mothers visiting post-natal clinics in the mostly rural Makueni County, south east of Nairobi, were recruited for the study. The prevalence rate for major post-natal depression was found to be 14.5%, which was consistent with the use of the EPDS elsewhere. Overall, the researchers found the local version of the EPDS "a suitable test" (p479) for use, with good psychometric properties (ie: reliable and valid). There were slight adaptations (ie: culture-specific) to the original EPDS for the Kamba-speaking women (eg: cut-off point for diagnosis of depression).

4.3. LOCAL CONCEPTS AND IDIOMS

Greene et al (2023) pointed out: "There is considerable variation in the presentation of mental health problems across cultural contexts. Most screening and assessment tools do not capture local idioms and culturally specific presentations of distress, thus introducing measurement error and overlooking meaningful variation in mental health. Before applying screening and assessment tools in a particular context, a qualitative exploration of locally salient idioms and expression of distress can help assess whether existing measures are appropriate in a specific context as well as what adaptations may improve their construct validity" (p496).

These researchers recruited over three hundred female Congolese survivors of intimate partner violence in Nyarugusu refugee camp, Tanzania, in 2015 to understand cultural conceptions of distress. As well as qualitative interviews (with 55 women), three global (or "Western") measures of distress were completed (by 311 women) (eg: "Harvard Trauma Questionnaire; Mollica et al 1992).

From the qualitative interviews, three problems emerged as salient for the women:

i) "Msongo wa mawazo" - "stress or too many thoughts, which was characterised by silence, preferring to be alone, unhappiness, lack of self-care, loneliness, sleeplessness, headache, and heart pain" (p499).

ii) "Huzuni" - "deep sadness, which was characterised by crying, silence, aggressiveness, being upset, looking down/head bent to the side, poor appetite, anger, and losing hope" (pp499-500).

iii) "Hofu" - "fear, which was characterised by preferring to be alone, worry, being easily shocked, trembling, feeling unsettled, avoiding eye contact with others, and avoiding or being afraid of one's husband and other people" (p500).

Factor analysis of the three psychometric questionnaires produced three factors which were similar to those found in the qualitative interviews.

This study supported the idea that local idioms of distress match the "Western" measures of mental health - ie: "the local 'cultural fit' of globally used tools for measuring mental health" (Greene et al 2023 p496).

This study focused on specific mental health problems related to trauma rather than all mental disorders. It was a mixed-methods study (ie: using both qualitative and quantitative methods).

Singh and Sharan (2023) described "asrat" in India. "Rather than being located in an individual body, asrat afflictions are shared, most often within a household or kinship group" (Singh and Sharan 2023 p457) [2]. Sufferers often seek help at a Sufi shrine.

Asrat can be seen as a "cultural concept of distress". "Like biomedical modes of classification, such concepts may be seen as having their own forms of rigour, consistency, and replicability... As outlined ahead, the concept of asrat includes a mode of aetiological understanding, linked to particular practices and techniques of care and treatment that are replicated over time, often across large geographical distances in disparate shrines" (Singh and Sharan 2023 p458).

Asrat is also an example of "shrine-based healing for mental illness" (Singh and Sharan 2023 p459).

Tekola et al (2023) explored "how depression is conceptualised and communicated among community members and primary care attendees with depression in rural Ethiopia" (p413). Individual interviews with 28 adults with depression and focus group discussions with twenty-one community members were undertaken in the Sodo district of the country.

Depression was not perceived as a mental illness, but as "a normal reaction to the stresses of life" (Tekola et al 2023 p412). Symptoms reported "only partially matched symptoms listed in the current diagnostic criteria for depressive disorders. In all participants' accounts, spiritual explanations and

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[2] Singh and Sharan (2023) commented: "As Gold and Gold (2014) assert: 'the social world affects the brain no less than a stroke or a tumour would' (p140). The household, we might say, is perhaps the single most critical component in the daily habitation of the social world. And further, it is the theatre in which the pressures of mental illness are often most starkly expressed, for patients, caregivers, and family members" (p470).

traditional healing were prominent" (Tekola et al 2023 p412). The symptoms not in Western diagnostic criteria included feeling dizzy, headache, disliking noise, and an urge to shout, while sleep problems, loss of interest, and wanting to cry are common to Western criteria. In this study, "participants with a diagnosis of depression labelled their problems as an illness but still perceived the cause as primarily social in nature" [eg: relationship problems] (Tekola et al 2023 p420). But sometimes more than one explanation was given concurrently. "For example, one of the women who said her illness is related to spirit attack... also said the death of her parents and sibling had impacted her mind and worsened her illness. Some of the participants' seemingly economic explanations also had a spiritual tone. For example, some of the participants associated their perceived inability to succeed in life despite hard work with a spiritual influence, eg: being cursed or being bewitched or an evil spell being sent to them by others" (Tekola et al 2023 p420).

This study showed that "the experiences and expressions of illness are embedded in the individual's social and cultural context" (Tekola et al 2023 p413).

In Uganda, unmarried teenage pregnancy is one of the highest rates in sub-Saharan Africa. These individuals experience stigma and shame, particularly in traditional, rural communities, and depression and suicidal behaviour are consequences. Families and communities often promote marriage, which can increase depression and suicidal behaviour. Mothers helped to become independent "appeared to fare better psychologically" (Webb et al 2023 p537).

Webb et al (2023) reported an ethnographic study of rural teenage mothers. Discussion groups were held with girls and women, and community stakeholders.

4.4. TRANSDIAGNOSTIC PSYCHOTHERAPY

"The increasing global need for mental health care has led to a search for efficient, effective treatments that are based on both local cultural healing traditions and scientific evidence" (Tietjen 2023 p484). An example of this is "Buddhist-Informed Therapy for Bhutan" (BT-B), which has the goals of "preserving traditional culture, improving psychological well-being for its citizens, and integrating Buddhism into solutions for contemporary social issues" (Tietjen 2023 p484).

The combination of Western evidence-based and local ideas is known as a transdiagnostic approach to psychotherapy (eg: Barlow et al 2011). "Listening to the client's narrative, the therapist identifies the need to address an evidence-based principle, bridges it with reference to one or more conceptually linked core Buddhist principles, and guides the client to apply their own cultural wisdom to produce change in thoughts, feelings, and behaviour" (Tietjen 2023 p485).

Tietjen (2023) described the development of BT-B between 2017 and 2019 as she worked as a clinical psychologist in a hospital in Thimphu, Bhutan. "Referring to familiar Buddhist concepts in psychotherapy may help to reduce the stigma that accompanies mental illness in Bhutan and increase willingness to use mental health services. It may also empower clients by enhancing a sense of pride in their own culture, countering the widespread perception among Bhutanese that Western knowledge is superior to their own. For contemporary Bhutanese, a treatment approach that integrates Western and Buddhist wisdom may be more useful than one rooted in either system alone by facilitating the development of cognitive flexibility..., a marker of mental health and a practical asset for residents of a society in which values, priorities, and ways of life are in transition" (Tietjen 2023 p493).

4.5. INDIGENOUS HEALING

There is a debate around the place of indigenous (or traditional or religious) healing in GMH. Summerfield (eg: 2014) argued that GMH ignores indigenous healing because of the "global deployment of the narrowly biomedical model of mental disease" in GMH. While Kleinman (eg: 2012) saw "Global Health" as "a corrective to the academic dominance of biological psychiatry in appealing to 'those health professionals and students for whom social justice and care for the suffering of the poor are central, and have moral force'" (Csordas 2023 pp443-444).

This debate can be described as (treatment) efficacy (as emphasised in Western psychiatry) versus (treatment) experience (as studied in anthropology) (Csordas 2023). But these two ideas may not be mutually exclusive. An example of how individuals make sense of both biomedical and indigenous approaches can be seen in a case study quoted in Kristensen (2019) of the Mapuche in Chile. "'Mapuche illnesses' are spiritual illnesses that have no apparent organic pathology and often manifest in psychological and diffuse physical symptoms, though they are not always the result of psychological or social distress. A young girl named Wanglen suddenly collapses and falls into a coma. After her hospitalisation in an intensive care unit, her parents consult both an herbalist and shaman. The doctors diagnose Guillain-Barré syndrome, while the herbalist and shaman agree that she suffers susto (fear/fright) from when the soul was captured by spirits. Wanglen's parents are grateful to the hospital staff for keeping her alive with biomedical technology, but believe Mapuche medicine is responsible for her miraculous recovery. For Kristensen, Wanglen's case highlights cultural, socio-economic, and political realities as 'patients are positioning themselves within webs of meaning as well as structures of power' (2019 p14)" (Csordas 2023 p446). This can be called a "pluralism of healing systems" (Csordas 2023 p447).

Csordas (2023) proposed a "rhetorical model of the therapeutic process" "to help orient and enhance the robustness of GMH's encounter with indigenous healing" (p448) (with four components):

i) Disposition - How the afflicted person is immersed in their community and its religious/indigenous views, and so who will help them change.

ii) Experience of the sacred - The everyday religious/indigenous experience that could bring about positive change.

iii) Elaboration of alternatives - How change is performed.

iv) Actualisation of change, "including what counts as change as well as the degree to which that change is regarded as significant by participants; this actualisation may occur in an incremental and open-ended fashion without definitive outcome, may require repeated treatments, and may endure for longer or shorter periods of time" (Csordas 2023 p449).

Csordas (2023) argued that "[E]ach of these components is essential to therapeutic process, and each is rhetorical in the sense that it corresponds to an aspect of transformative persuasion whether it is enacted in psychotherapy or in traditional healing, or whether it is found in a low, middle, or high-income country" (p449). Table 4.1 gives an example of a Navajo man in North America.

"Patient" - "Marvin", 64 year-old Navajo man with a history of alcohol dependence and possibly major depression.
Disposition - Immersed in community and "Native American Church", which uses "peyote ceremonies" (ie: the mescaline-containing cactus peyote).
Experience of the sacred - Words of the "roadman" (peyote priest) and peyote-induced visions.
Elaboration of alternatives - The roadman gave a spiritual explanation of the drinking behaviour, which was less stigmatising than being labelled an alcoholic.
Actualisation of change - "Marvin" was sober one year later.

Table 4.1 - Example of the rhetorical model of Csordas (2023).

4.6. TRADITIONAL AND FAITH HEALERS

The personal experience and attributes of illness were studied by Ayinde et al (2023), who interviewed 85 adults in Nigeria, Ghana, and Kenya who had recently received treatment from traditional and faith healers (TFHs) for psychosis. Analysis of the interviews produced six main themes:

i) Illness terms - "Participants described psychosis in language that indicated efforts at making sense of the underlying nature of the disorder, communicating distress to others, or hinting at its perceived aetiology. Terms used included lay terms such as 'madness', 'crazy', 'stupidity', and 'insane'; terms that suggest the brain as the seat of the illness such as 'mental illness', 'mental disorder', 'mental problem', and 'psychiatric' [sic]; terms suggestive of a physical origin of illness such as 'malaria', 'high fever', and 'headache'; those suggesting a supernatural origin of illness such as 'spiritual illness'; as well some biomedical terms such as 'bipolar', 'depression', 'mania', and 'phobia'" (Ayinde et al 2023 p524).

ii) Description of psychosis - Interviewees described the "marked change" in themselves, and their lives with the onset of psychosis. Odd behaviour, social withdrawal, and aggression were common symptoms mentioned.

iii) Impact of psychosis on life - Major consequences (mostly negative) were experienced across the different areas of life (eg: family; occupation;

education) due to the bout of psychosis. For example, a woman in Kenya stated: "For me I just sit doing nothing... I cannot fend for myself, people disregard me, I am just there without hope. I am not married, I am getting old and still my family has to take care of me" (p525).

A positive exception was one one Ghanaian man: "Out of my experiences of this illness I have been able to write a book and I was able to do all this because I had favour from the gods... As I was telling you earlier, I feel good about myself now... I can see my life has changed. It has made me see so many things in the world and now I see myself as a special person" (pp526-527).

iv) Causal attributions of psychosis - Supernatural causes were most frequently mentioned (eg: "spiritual attack"; "work of the enemy/evil-doer"; failure to carry out certain traditional practices). Alternative explanations included "thinking too much", "worrying a lot", psychoactive substances, "malaria", and being hit on the head.

v) Response to psychosis - Although all interviewees had been treated by TFHs, other care providers had been visited by many of them, including hospitals. "Reasons cited for the plurality in care-seeking included perceived non-improvement in symptoms, perceived poor or inadequate communication from practitioners, perception that the illness was of supernatural origin, as well as the presence of associated somatic symptoms which respondents felt was an indication of the dual causality (physical/spiritual components) of the illness. When the causal attribution of illness was suspected to be both physical and supernatural, participants indicated that they attended a conventional medical facility either before or after consulting a TFH" (Ayinde et al 2023 p528).

vi) Experience of care - "Overall, at each site, a large majority of respondents reported being satisfied with the treatment received from the healers and would recommend similar treatment to other individuals with psychosis" (Ayinde et al 2023 p529). Faith and spirituality were central in the treatment (appendix 4B), but there were some harmful practices (eg: use of restraint).

There were similarities and some differences between the interviewees' experiences and views in the three countries. For example, behavioural symptoms of psychosis (as compared to psychological and somatic) were reported more in Ghana than elsewhere, while all three groups agreed on the importance of supernatural causal attributes (compared to psycho-social and biological).

The researchers felt that there was potential for collaboration between TFHs and biomedical services to improve the outcome of psychosis. They stated that the study provided "a better understanding of the elements of the healer–help seeker relationship and the nature of care received from TFHs for the purpose of: 1) designing culturally nuanced mental health services that not only improve symptoms and disability, but also address patients' culturally relevant therapeutic goals and existential anxieties; 2) harnessing locally available resources in the form of human resources and practices that are already recognised and used by TFHs and are perceived to be helpful by their patients; and 3) improving the care environment and minimising harmful practices if they exist" (Ayinde et al 2023 p531).

Kong et al (2023) noted that there are generally two responses to TFH and biomedicine - "one might be to dismiss outright the claims of non-biomedical practices, like faith-based healing, working towards the phasing out of these 'primitive' practices and beliefs to be replaced with a 'universal' standard of care, diagnostic categorisation, and/or normative frameworks (such as human rights) ['universalist']. A second response, in contrast, is to adopt a relativist position, suggesting that claims of biomedical psychiatry and faith-based healing might be equally valid depending on the local context, but neither has priority over the other given the absence of any universal criteria ['relativist']" (p429). Kong et al (2023) themselves preferred another approach which combined both TFH and biomedical views ("reciprocity and collaboration").

Applying this idea to recovery, they discussed the concept of "recovery as discovery". Recovery occurs at multiple levels, which allows the combination of the different approaches. For example, an individual may receive psychiatric treatment while undergoing traditional ceremonies around relations with ancestors. Put simply, healing as a spiritual aspect beyond the physical.

However, I am not sure how this combined approach deals with direct contradictions between the faith healer and the psychiatrist, say.

"Local faith actors" (LFAs) is a term used in the field of humanitarian protection, but there is a place for them in mental health and psycho-social support (MHPSS), argued Storer and Torre (2023). These researchers used the example of Christian (and to a lesser extent Muslim) actors in northern Uganda and trauma healing (with after-effects of the Lords Resistance Army).

"MHPSS practitioners have long advocated for the formal inclusion of religious actors in the delivery of psychological assistance... A growing clinical and academic literature argues for the need of faith-sensitive MHPSS and for establishing collaborations with LFAs... Faith-based organisations, including the Lutheran World Federation, World Vision and Islamic Relief, have increasingly started offering mental health services and lay mental health techniques such as psychological first aid and psychological counselling trainings to religious leaders... In northern Uganda, several mental health programmes are already delivered by faith leaders..." (Storer and Torre 2023 pp509-510).

Often LFAs are used as local facilitators of "humanitarian apparatus", but this often overlooks "essential aspects of their social role in the communities where they exist and operate" (Storer and Torre 2023 p516).

Storer and Torre (2023) ended: "Contemporary humanitarians advocate for a global mental health movement premised on human rights, individuated treatment and a recognition of the structural determinants of mental distress. Pursuing this laudable aim, it is assumed that local actors are conversant and invested in Western notions of mental health. Yet by neglecting the complex and fraught therapeutic landscape of northern Uganda, flows of humanitarian resources directed at LFAs may risk overlooking the intricate histories, relationships and agendas of these actors. Considering these factors and complexities, we caution against the recent enthusiasm that sees enormous potential in training and relying on LFAs to deliver mental health assistance" (p517).

4.7. PASUNG

Baklien et al (2023) observed: "Caring for relatives with a serious mental illness in everyday life presents an enormous challenge for families around the world. For too many families, the use of physical restraint and confinement seems the only possible strategy. Hundreds of thousands of women, men, and children with mental illness across many countries have, at least once in their life, been shackled in unhygienic conditions with limited access to a toilet and food" (p566).

"Pasung" is the term used in Indonesia to chain or tie such individuals to wooden blocks, say, or lock them in somewhere. Baklien et al (2023) undertook a qualitative study of the meaning of the practice, despite legislation against it.

Eight family members who were using or had used parsung were recruited by mental health nurses in the city of Gunungsitoli, North Sumatra province, for interviews. Baklien et al (2023) summed up the findings that "pasung emerges in the disjunction between socio-cultural demands and the family's capacity to meet these demands. Struggling to understand the behaviour of a family member with mental illness, the family tries to cope with neighbourhood reactions to ever more visible behavioural signs alongside managing their everyday life. These struggles, in turn, make their social situation increasingly stressful, which initiates a process of depersonalisation as a response. Moreover, the prevailing socio-cultural values convey a need to act according to expected norms. As such, pasung materialises as a socio-culturally accepted practice that allows families to take back control in stressful social situations. In sum, when families feel overwhelming emotional stress and a sense of powerlessness, they try to resolve their situation by using pasung to regain control and thus manage their lives" (p566).

When the relative with mental illness behaved in ways that the family member could not understand or food difficult, then pasung became an option. For example, participants reported "he destroyed things at home such as cauldrons, pots, light bulbs, mirrors" (p570), or "she screamed at the cemetery near here, until the agitation of the neighbours called me home from work" (p571), or "hitting other people" (p572). The reaction of neighbours was seen in this quote: "She has been locked up since she disturbed people. Her brother said, just lock her up so that the neighbours don't make a fuss; it has been about six months since her brother and I locked her in the room. The important thing is that she is not behaving strangely" (p571). While another participant explained: "The whole family agreed to put him in that room, because he likes to go everywhere and make a lot of noise, which disturbs people. He went to the shop where he destroyed the goods and there was a scene. Also, the head of the village warned us to look after our child and to look for ways to prevent the child from running around and being noisy" (p572).

In 2010 the "Indonesian Freedom from Forcible Restraint (Pasung) of Mentally Ill Persons" or "Gerakan Bebas Pasung" (GBP) movement was started, and subsequently legislation was passed (Hunt et al 2023).

But Hunt et al (2023) reported the continued use of Pasung in a case study in central Java. Based on interviews with local government officials and healthcare workers, and participant observation in a mental health facility practising Pasung, the researchers concluded that "the continuing use of Pasung is due to a combination of access to care issues and a widely held explanatory model of mental illness characterised by strong curative beliefs that, when disappointed, lead to a sense of threat and hopelessness" (Hunt et al 2023 p552).

4.8. GAZA

Diab et al (2023) interviewed thirty mental health providers (including psychiatrists and psychologists) in Gaza in 2018 about the service users of the Gaza Community Mental Health Programme. "Gaza has been under continuous military attack since 1967 and under a strict militarily enforced blockade since 2006. There are significant restrictions on movement in the area as well as limited access to clean water, health care, and medical services. Unemployment, lack of educational opportunities, and food insecurity exacerbate health risks... Moreover, poor and worsening quality of life and an increased level of human insecurity have negatively affected the psychological and physical health of the population of Gaza" (Diab et al 2023 p577).

The interviews were semi-structured, and included questions like, "What kind of clients do you see?", "What are the main problems that your clients come to see you for?", "What are the main mental health problems that people in Gaza have?", and "How do you think the blockade on Gaza affects people living in the Strip?" (p579).

The main theme that emerged from analysis of the transcripts was "the impact of the blockade on mental health and quality of life of clients". The researchers explained: "The main recurrent Arabic words that emerged from our analysis were Makhnogeen (feeling suffocated), Masjoneen (feeling imprisoned), and Maazoleen (being segregated). These expressions indicate manifestations of distress in relation to personal and cultural meaning... and reflect the psychological and emotional state of people living under conditions of strict blockade... These idioms communicate the collective nature of suffering rather than only individual experiences. They are not diagnostic entities that require treatment but terms through which distress is expressed and by means of which social support is mobilised" (Diab et al 2023 p579). Table 4.2 gives some of the quotes associated with this theme.

- "people cannot escape to look for opportunities. It is like a big prison. They cannot get in or out" (male psychiatrist; p580).
- "the blockade affects all facets of life including the physical environment. Pollution and contamination are spreading within the community" (female social worker; p580).
- "we feel that people have lost positive energy and they [clients] are not motivated to participate in social activities and cannot look after one another. Also, people have no savings and are anxious about their future" (female psychologist; pp580-581).
- "due to the blockade we do not have enough medications, we cannot provide medication for all cases, clients are not able to buy them which will lead them to a major setback" (male psychiatrist; p581).
- "people cannot complete their studies due to economic hardship. Also, poverty represents an environment [in which] to develop mental health problems. I believe that poverty is the worst violence against humankind and economic conditions influence all social conditions of people. This leads to development of traumas" (female social worker; p582).
- "PTSD is widely common among children because of the unpleasant situation. I face problems in dealing with them as the trauma is continuous and I don't have a role in changing it" (female social worker; p583).

Table 4.2 - Quotes from Diab et al's (2023) interviewees.

Diab et al (2023) summed up: "Idioms of distress that emerged from our participants' narratives reflected the socio-political environment where people remain constrained and oppressed. Several idioms indicated a sense of restriction and suffocation among the people of Gaza. Therefore, definitions of illness reflect the sense of imprisonment that people experience as a consequence of the ongoing blockade of the Gaza's borders" (pp583-584).

Focusing on the individual in terms of treatment has limited benefits as individuals are embedded in their social environment. Thus, "the importance of adopting an approach to mental health that includes understanding psychological indicators in a broader framework informed by human rights and social justice" (Diab et al 2023 p577). The situation has worsened since this research.

4.9. APPENDIX 4A - MENTAL HEALTH GAP ACTION PROGRAMME

Attempts to close the treatment gap (and to establish universality of mental disorders) have been formalised in the World Health Organisation's "Mental Health Gap Action Programme (mhGAP) Guidelines for Mental, Neurological and Substance Use Disorders" developed in 2010. Mills (2023) interviewed nine member of the group that developed the mhGAP Guidelines.

The Guidelines placed great emphasis on universality and standardisation. Universality is "'ambiguous and precarious' and is 'contingently and collectively produced'... as the result of the 'historically situated, distributed work of a multitude of actors' (Timmermans and Berg, 1997...)" (Mills 2023 p592).

"According to Lakoff (2005), standardisation, through reduction of complexity, specificity, and locality, makes an asset transferable across different contexts — achieving 'diagnostic liquidity'. Diagnostic liquidity in mental health thus 'requires consistent classificatory practice among doctors', and reliance on techno-scientific objects (Lakoff 2005...) that produce mental health diagnoses as 'coherent and stable'..., and durable entities... 'with universal properties'... The production of guidelines is one of the central practices through which 'the apparently universal validity of biomedical knowledge is materially and discursively forged via the standardisation of practice across multiple domains' (Lakoff 2005...)" (Mills 2023 p593).

Six themes around the construction of universality in the Guidelines emerged from Mills' (2023) analysis of the semi-structured interviews:

1. "Processes and practices of assembling expertise" - The twenty-one members of the "Guidelines Development Group" (GDG) were mostly psychiatrists, and "there were

no people who publicly identify as service users, psychiatric survivors, or people with psycho-social disability" (Mills 2023 p595).

2. "Decisions on what counts as evidence" - One interviewee talked of "a choice of giving priority to the results of systematic reviews" (p596), while another interviewee was aware of the criticism of "people saying actually what you are implementing is more use of medicines, with a risk of medicalising social problems" (p596).

3. "Framing cultural relativism as nihilistic" - The vast majority of evidence came from high-income countries, though this was accepted as universal because of concerns of cultural relativism. "For those interviewed, cultural relativism was understood to mean that 'social and cultural practices are so important that you couldn't do anything' and that 'evidence generated in one context cannot be applied in any other context' (R1 [Respondent]). This was understood as a 'prevailing nihilistic view that had really been very destructive actually', leading to a 'paralysis in the mental health sector' over the past 40 years (R1). The mhGAP Guidelines were thus imagined as having both political and cultural value in shifting this nihilism by showing 'you could have certain common rules that can be applied across contexts' (R1), and by moving 'mental health into an equal position with physical health' (R3)" (Mills 2023 p596).

4. "The delaying of complexity to prioritise action" - "Participants openly acknowledged potential problems with the Guidelines, explaining that it is still 'a fairly crude measure, but it's probably the best we can do for now' (R3); 'I feel that the decisions made were the best decisions that the group at this time could have made for public gain' (R7); 'any first version is not going to be perfect by a long way' (R6); and that 'there's a whole complexity to mental health care that cannot be captured in a 100 page guideline' (R1)" (Mills 2023 p596). In other words, it is better to act then to iron out the tensions, contradictions and complexities.

5. "The narration of tensions as technical rather than epistemological" - Tensions within the GDG were treated as technical (eg: one medication is better than another for treatment) rather than epistemological (eg: should other treatments be offered instead of

medication).

6. "The ascription of messiness to local contexts rather than to processes of standardisation" - Any problems with the implementation of the Guidelines was ascribed to the local context where they were applied.

Mills (2023) saw the GDG as "a form of 'negotiated universality'" (p598). The whole thing can be simplified into this quote from an interviewee: "the prescribing of medicines is the easiest way of at least doing something" (p598).

4.10. APPENDIX 4B - PSYCHOSIS AND SPIRITUALITY

Many individuals who experience psychosis use religion and spirituality as a means of coping with the illness. It can be seen that "religion embodies a system of beliefs and rituals, which encourages closeness to the transcendent and reflects the extent to which a person engages in these practices... Spirituality pertains to existential questions regarding one's meaning and life purpose, often viewing oneself as part of a wider spiritual or cosmic force" (Westhead and Georgiades 2025 p1).

What is the evidence concerning religion and spirituality in the maintenance and recovery of psychosis? Westhead and Georgiades (2025) performed a literature review, and found 35 relevant studies. Overall, religiosity/spirituality (R/S) played "a significant role in the maintenance and recovery of positive symptoms of psychosis" (Westhead and Georgiades 2025 p1).

Exploring the findings in more detail:

1. Maintenance of psychosis - R/S were positively correlated with positive symptoms of psychosis (eg: delusions; hallucinations), and these symptoms were more frequent in believers than non-believers.

2. Recovery: Positive religious coping (PRC) (eg: "God is supporting me") - Improved well-being, quality of life, treatment expectancy, and medication adherence.

3. Recovery: Negative religious coping (NRC) (eg: "God is punishing me") - Increased suicidality, positive symptom severity, and illness duration, and reduced social functioning.

The distinction between PRC and NRC was crucial in terms of recovery. PRC includes positive aspects of R/S (eg: prayer as a sense of comfort), as well as religious practice (and membership of groups), and seeking medical help. NRC includes thoughts around possession, punishment, and demons, and self condemnation, as well as seeking religious help (eg: exorcism) rather than medical for the psychosis.

How the hallucinations, for example, are appraised can be important. For instance, hearing voices interpreted as a sign that "I am the chosen one" is different to them as the voice of the devil or demons, or condemning versus supportive voices.

There were some differences in findings between the studies, which the researchers explained as a product of methodological differences (eg: measures of R/S; terms and definitions; country of study).

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5. TYPE OF EXERCISE

Exercise can vary in intensity, duration, and frequency. The intensity of exercise as beneficial to weight loss, and cardiovascular health, for instance, is debated. At one end is "high-intensity interval training" (HIIT) with short high-intensity bursts of activity at 80-95% of maximum heart rate, while at the other end is "low-intensity steady state" (LISS) exercise at 50-65% of maximum heart rate for longer periods (Wade 2025).

LISS puts less strain on the body, and can promote blood flow to skeletal muscles (Wade 2025).

Yang and Kwan (2024) compared HIIT, moderate-intensity continuous training (MICT), and LISS in eight variations with 96 25-45 year-old males in China. The exercise programme was performed three times per week for sixteen weeks. Various measures of physical and mental health were taken.

The eight experimental conditions were:

i) HIIT - Sprinting for 20-30 minutes divided into up to one minute bouts at 80-90% maximum heart rate.

ii) MICT - 30-45 minutes of running at 60-75% maximum heart rate.

iii) LISS - 30-45 minutes of jogging at 50-60% maximum heart rate.

iv) HIIT-LISS - alternating sessions of HIIT and LISS.

v) MICT-LISS.

vi) HIIT-MICT.

vii) HIIT-MICT-LISS.

viii) Control - no exercise sessions.

Overall, any exercise was better than no exercise in "significantly reducing BMI [body mass index] and body fat percentage, improving metabolic health, cardiovascular health, and cardio-respiratory function and enhancing quality of life and psychological state" (Yang and Kwan 2024 p1). The HIIT and MICT combination was found to be "most effective", though other types of exercise programme performed better on specific measures (eg: HIIT and blood pressure; MICT-LISS and heart rate). LISS alone was "less effective as an exercise modality, but it often shows better results when alternated with other types of exercise" (Yang and Kwan 2024 p13).

The study was quite small in size and duration with only middle-aged male volunteers, and the outcome measures and control of confounding variables was limited, by the researchers' own confession.

Masagca (2024) compared LISS and HIIT with random physical activity (RPA) among 144 college students over ten weeks. The exercise programmes were as follows (three times per week):

a) HIIT - 30 seconds of exercise and fifteen seconds of rest for nine different exercises (eg: jumping squats; push ups).

b) LISS - 10-15 minutes of jogging.

c) RPA - 1 hour of physical activities of own choice.

All exercise types showed improvements in various physical fitness measures compared to baseline, "with LISS enhancing flexibility, cardio-respiratory endurance, and upper-body muscular endurance, HIIT improving upper body flexibility, cardio-respiratory endurance, and upper limb muscular endurance, and RPA enhancing all aspects. However, the training programme had no impact on core muscle endurance in both males and females, with women not seeing improvement in core muscular endurance. Nevertheless, the workout regimen enhanced the core muscular endurance of male participants" (Masagca 2024 p493).

Not an astounding revelation, but it is fair to say that any exercise is better than none for the average person, and the success of the different types of exercise programmes depends upon the outcome measure of interest (eg: weight loss; blood pressure reduction). Personal preference is important as individuals need to perform the exercise of choice consistently over time. For elite athletes the small benefits from one type of exercise over another will matter (depending on the sport played).

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