

Correspondence

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A nuanced perspective?

In their editorial, White & Sashidharan point to the putatively good outcomes in schizophrenia in low- and middle-income countries (LMIC), ‘where populations may not have access to medication-based treatments’.¹ This evidence is offered as a caution against scaling up biomedical interventions in LMIC. White & Sashidharan then make a plea for ‘a more balanced exchange of knowledge . . . between high-income countries and LMIC. However, in only citing evidence from the World Health Organization (WHO) studies of schizophrenia, and neglecting a wealth of evidence from studies in LMIC, they do not heed their own advice for a greater exchange of knowledge. In fact, research conducted by investigators in India, Ethiopia and China suggests that the provision of biomedical treatment does, in fact, improve outcomes in persons with schizophrenia.’² Furthermore, by only citing the WHO studies, White & Sashidharan do not, despite the title of their editorial, offer a nuanced perspective on this question. When considering the evidence from the long-term research on schizophrenia outcomes in LMIC, there is no doubt that the picture is one of heterogeneity and complexity.² Thus, by only citing the WHO studies, White & Sashidharan fail to acknowledge the work of a large number of psychiatric researchers from LMIC.

It is difficult, if not impossible, to defend the statement, ‘better outcomes for complex mental health difficulties in LMIC . . . may be a consequence of the multiplicity of treatment/healing options available in LMIC compared with high-income countries’. First, I would hazard to guess that there are as many, if not more, options for treatment and healing in London, New York, Paris and Sydney than there are in New Delhi, Beijing, Lagos and Rio de Janeiro. For example, in much of Indonesia the options for care are so limited or nonexistent that families often resort to *pasung*, the practice of chaining, shackling or confining psychotic individuals, in an attempt to protect those individuals from harming themselves or others.³ Second, having a multiplicity of options does not necessarily result in better outcomes. It can also lead to a continuous sampling of ineffective cures offered by charlatans.

I do not mean these comments to be taken as a tacit endorsement of the indiscriminate use of psychotropic medication. Antidepressants and antipsychotics are less effective than desired and both are associated with troubling side-effects. Rather, these comments are offered in the hope that White & Sashidharan, as well as others, will be prompted to provide a truly nuanced perspective on what is needed to improve the lives of individuals who experience severe mental illness, wherever they reside.

- 1 White RG, Sashidharan SP. Towards a more nuanced global mental health. *Br J Psychiatry* 2014; **204**: 415–7.
- 2 Cohen A, Patel V, Thara R, Gureje O. Questioning an axiom: better prognosis for schizophrenia in the developing world? *Schizophr Bull* 2008; **34**: 229–44.
- 3 Puteh I, Marthoenis M, Minas H. Aceh Free Pasung: releasing the mentally ill from physical restraint. *Int J Ment Health Syst* 2011; **5**: 10.

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Authors’ reply: We feel it is important to respond to several points that Dr Cohen made in his letter. In our editorial, we did not propose that psychotropic medications should not be part of the treatment options for people with mental health difficulties living in LMIC. Instead, we questioned whether these medications should necessarily be the front-line treatment, and highlighted concerns about their long-term use. We cited the most comprehensive studies conducted to date to highlight that outcomes for serious mental health difficulties in high-income countries (HIC) are not superior to those in LMIC. The suggestion that outcomes were better in countries where populations may not have access to antipsychotic medications is supported by the WHO finding that ‘Patients in developing countries experienced significantly longer periods of unimpaired functioning in the community, although only 16% of them were on continuous anti-psychotic medication (compared with 61% in the developed countries)’.¹

A recent meta-analysis of studies that have investigated antipsychotic medication for maintenance treatment of schizophrenia found that antipsychotic medications were superior to placebo in preventing relapse, and that the medication–placebo difference was smaller in longer, compared with shorter, trials.² Various methodological issues were noted with the studies.² More rigorously controlled long-term trials are required in both HIC and LMIC to investigate the impact of antipsychotic medications on recovery (incorporating a focus on social participation and citizenship) from serious mental health difficulties. Consistent with a previous *British Journal of Psychiatry* editorial³ and the Kampala Declaration,⁴ we believe that it is important for people to have the right to freely choose whether they take psychotropic medication on the basis of balanced information about the potential long-term benefits and costs of these treatments.

Dr Cohen casts doubt on the suggestion that the multiplicity of treatment/healing options for mental health difficulties available in LMIC may be associated with better mental health outcomes there. He points out that a range of potential treatment options is also available in HIC. Halliburton has spoken directly to this point, by commenting that in ‘developing country sites in the WHO studies, multiple medical systems exist within the mainstream and are often considered mutually compatible, whereas in most developed sites allopathic medicine is more hegemonic and “alternative” systems are more marginal’.⁵ Indeed, it has been suggested that, over the past 200 years, complementary and alternative systems have contended with orchestrated resistance from biomedicine.⁶

Whether non-biomedical interventions provided in HIC or LMIC are safe and efficacious is a matter for careful consideration and empirical investigation. Recent evidence from Ghana has indicated that human rights abuses can occur not only in non-biomedical settings (such as prayer camps), but in psychiatric hospitals as well.⁷ It is estimated that two-thirds of the global population rely on traditional forms of medicine used concurrently with, or as alternatives to, biomedicine.⁸ We would suggest that dismissing out of hand the contribution of non-biomedical practitioners as the work of ‘charlatans’ potentially risks disenfranchising people from important sources of support.

- 1 Jablensky A, Sartorius N. What did the WHO studies really find? *Schizophr Bull* 2008; **34**: 253–5.
- 2 Leucht S, Tardy M, Komossa K, Heres S, Kissling W, Salanti G, et al. Antipsychotic drugs versus placebo for relapse prevention in schizophrenia: a systematic review and meta-analysis. *Lancet* 2012; **379**: 2063–71.
- 3 Morrison AP, Hutton P, Shiers D, Turkington D. Antipsychotics: is it time to introduce patient choice? *Br J Psychiatry* 2012; **201**: 83–4.
- 4 World Network of Users and Survivors of Psychiatry. *Kampala Declaration*. 2009 (http://www.un.org/disabilities/documents/wnusp_kampala.doc).