THE "WORLD MENTAL HEALTH" FRAMEWORK: DOMINANT DISCOURSES IN MENTAL HEALTH AND INTERNATIONAL DEVELOPMENT

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ABSTRACT

This paper draws on experiences and research in mental health and international development to explore a dominant "World Mental Health" discourse. This kind of analysis provides a starting place to examine the critiques and ongoing theorizing of a global mental health ideology. Seeing the field as it is socially organized (Smith, 1987, 1990a, 1999) necessitates an understanding of how an ideological "World Mental Health" is discursively arranged as part of a global undertaking to decrease poverty and increase capitalist productivity and trade. Through this exploration of the discourses in use internationally, I argue that rediscovering local truth is possible as researchers pursue and share knowledge that has as its starting place a way of knowing outside these dominant discourses.

> We need a new sociology of knowledge that can pick apart a wide body of commentary and scholarship: complex international law; the claims and disclaimers of officialdom; postmodern relativist readings of suffering; clinical and epidemiologic studies of the long term effects of, say, torture and racism (Farmer, 2003, p. 241).

The emphasis on global understandings and solutions *for* mental health problems provides a convenient distraction from our understanding of economic globalization's impact *on* mental health problems. In this paper I introduce some important ideas, "claims and disclaimers of officialdom" (Farmer, 2003, p. 241), and discourses that are used in understanding and managing mental health work globally, in developing countries and beyond.

The mental health discourse is vast. My interest here is in offering background on how mental health work is becoming conceptualized as part of a global undertaking to decrease poverty and increase capitalist productivity and trade. I explain how mental health is part of the mandate of the World Health Organization (WHO), the pre-eminent body in developing a global understanding and policy for health programs, as well as other key organizations influencing the directions of health care internationally. The World Bank and the International Monetary Fund (IMF) are important players in developing discourse on the relation between mental health and improved productivity or "development." As I explore in this paper, these discourses are not entirely separate even though they originate in different organizations with distinct goals for economic and social development. Together these "mental health"

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and "development" discourses make up a "World Mental Health" framework that I later describe as used in practice in the World Assembly for Mental Health. By conceptualizing this framework, I offer a glimpse inside the discourses of what is understood globally, versus locally, in mental health. I present an analysis that aims not to discount the value of medical or Western psychiatric discourses, but rather to hold these notions as discursive and ideological in what Smith (1990a) and others (Campbell & Gregor, 2002) refer to as a "conceptual frame."

BACKGROUND AND ANALYTIC APPROACH

Working in mental health services development in West Africa through an international development organization, I became acutely aware that mental illness, disability, and inequalities in health were not simply biological, psychological, and social byproducts as I had come to understand them in my training and Western practice (Jakubec, 2001; Jakubec & Campbell, 2003). Rather, I began to see the social constructions of illness, and the environmental and other conditions of globalization that exclude people from community life. These factors are both more complex and more basic than any psychological explanation, conceptual frame of "burden of disease," *DSM-IV* category (American Psychiatric Association, 1994), or ICD-10 framework (World Health Organization, 1993) could articulate. I was struck by the extent to which basic fundamental needs and human rights were denied to people with mental illness in the developing world. Even more troublesome, however, were the ways in which those needs were being articulated in the discourses and being met through often irrelevant or unsustainable modes of psychology, psychiatric nursing, social work, and medicine, and an array of goods and services (Jakubec & Campbell, 2003).

I point to these troublesome experiential accounts not as way of aligning with, or speaking for, the suffering of others but rather as a point of entry for understanding how the mental health and development ideology fails to explore those realities. Looking at those realities alongside my critique of Western approaches to mental health, we can see the magnitude of the global challenge posed by mental health problems. Only 25% of people afflicted in even the most developed areas of India will ever receive diagnosis and treatment for schizophrenia. In West Africa the proportion is even smaller. Forty percent of countries in the world have no policy or legislation for mental health concerns (BasicNeeds, 2003). The impact of mental health problems on the lives of large numbers of individuals, their families, and communities is enormous.

Through the dominant conceptual frame for mental health and development, which I examine here, an agenda for aid is being constructed, one that I propose must be approached critically for its global rather than local orientation. This analysis of dominant discourses in mental health and development is inspired by Canadian sociologist Dorothy Smith's approach to studying everyday life: the social organization of knowledge (Smith, 1987, 1990a, 1999, 2002). In this approach, the study of ideology is central to understanding how models and frameworks (such as the "World Mental Health" framework I outline below) bypass everyday lived experience. The knowledge they generate is constructed within discourse, which represents a form of coding and textual organization (Gardiner, 2000). Understanding how people "participate in discursive activity," as in Institutional Ethnographic approaches (Campbell & Gregor, 2002, p. 41), necessitates a careful analysis of the weave of texts as they

are connected and used in organizational practices. DeVault and McCoy (2002) explain:

> For Smith, discourse refers to a field of relations that includes not only texts and their intertextual conversation, but the activities of people in actual sites who produce them and use them and take up the conceptual frames they circulate. This notion of discourse never loses the presence of the subject who activates the text in any local moments of its use (p. 772, n. 2).

In a careful review of the dominant conceptual framework and an exploration of the discursive arrangements of that international mental health and development framework, I uncover a dominant and globalized discourse worthy of critique.

CONCEPTUAL FRAMES TO MANAGE MENTAL HEALTH

Exploring the discourses on "World Mental Health" and "development" helps us understand how our experiences in mental health work in developing countries come to be organized. Development workers and researchers join with the organizers of development in managing and helping so-called "underdeveloped" or less Industrialized nations (Jakubec & Campbell, 2003; Mueller, 1995). A conglomerate of global forces and organizations, including the World Bank, WHO, and the World Federation for Mental Health (WFMH), is in charge of conceptualizing, planning, funding, and directing mental health work. Development workers and researchers are assigned by these organizations to carry out their work of understanding and meeting mental health needs in the "developing" world. Let's proceed with an analysis of the institutional discourses that guide the work of each organization.

The World Health Organization

The World Health Organization is an international health institute initially forged to combat common threats such as plague, yellow fever, smallpox, and other infectious diseases (World Health Organization, 2000a). As the directing and coordinating authority on international health work, WHO functions:

> to promote biomedical and health services research, promote improved standards for teaching and training of health professionals, to establish and stimulate international standards for biological, pharmaceutical and similar products, to standardize diagnostic procedures, and to foster activities in the field of mental health (World Health Organization, 2000b, p. 1).

WHO works closely with other organizations in the United Nations and in partnership with the World Bank and other bilateral, intergovernmental, and non-governmental organizations (World Health Organization, 2000b). Goals of WHO include: "harmonizing legislation and terminology, and fostering the dissemination and exchange of information on these subjects" (World Health Organization, 2000b). Contributions in health policies are designed to "reach beyond the health sector to constitute an integral part of sustainable development." Each of WHO's working areas is said to reflect the reach for "equity and sustainable development." In this process, "international and cross-sectional health partnerships" are to be forged to achieve "health for all." The functions of WHO in achieving health for all are in four main areas: world-wide guidance, setting global standards, strengthening national programs, and developing and transferring technologies, information, and standards. Mental health is included in the category of non-communicable diseases, although it is allocated its own division within WHO. At the division level (including mental health), the following strategies are promoted:

> Comprehensive chronic disease control and the application of cost-effective methods of detection and management and major sustained global campaigns to encourage healthy lifestyles, healthy public policies and acceleration of research are promoted in the agency (World Health Organization, 2002).

Conceptualizations of global mental health. Global objectives for mental health, treatment approaches, training, and research are articulated in WHO press releases, research reports, and documents (World Health Organization, 2001). As I draw together a picture of the evolving framework for "World Mental Health," I make particular note of the notion of "measuring the burden of disease" and the trend towards conceptualizing mental health problems in the framework of "Disability Adjusted Life Years" (DALYs) (Desjarlais, Eisenberg, Good, & Kleinman, 1995, p. 5). Such concepts are specifically drawn from the "new Global Strategies for Mental Health" unveiled by then-WHO Director-General Gro Harlem Brundtland in 1999 (World Health Organization, 1999). In announcing the strategy, Dr. Brundtland reported that the burden of mental illness was among the most important contributors to the "global burden of disease." This burden is measured by the DALY, which was jointly identified for this purpose by WHO, the World Bank, and the Harvard University Medical School Department of Social Medicine and associates (Desjarlais et al., 1995). Special risk groups are identified and are to be targeted in this strategic approach to accounting for the "impediment to social and economic growth" that mental illnesses pose to nations (Morrall & Hazelton, 2004, p. xi). Specifically, the WHO director-general identified depression and epilepsy as particular areas in which WHO proposes strategies to improve treatment rates so as to remedy the significant impediment these illnesses pose globally. The promotion of "effective intervention and essential drugs" to control diseases was reported as a key strategy, along with generally "monitor[ing] the mental health of the world" (World Health Organization, 1999).

Mental health programs and policy. Several models, quality assurance frameworks, and research goals/protocols have been developed over the years to bring into action the goals and conceptualizations of "doing" mental health in the global context. The textual sources of the social relations of "doing" mental health programs globally have evolved over time. Work within a global framework of mental health began in the 1960s with WHO's International Pilot Study of Schizophrenia (Sartorius & Harding, 1987). Originally designed as an exploration into the universality of schizophrenia and other forms of psychosis, this study grew over the period of 1966 to 1975.and continually evolved using changing designs. Standardized assessment instruments, modern case-finding techniques, and the large-scale and comparative power of the studies are discussed in many works (Sartorius & Harding, 1987). Sartorius and Harding's foundational work was extended, and treatment outcomes explored, in several follow-up studies (see, for example, Harding et al., 1983). Later studies using general health questionnaire surveys further built on the earlier work. Sartorius et al.'s (1993) research expanded to cover 15 sites internationally, surveying 5,604 persons to produce a database to explore the nature of psychiatric disorders and disability over time.

Researchers expanded and developed their work to construct a picture of assessment and treatment strategies. Other WHO research activities aimed to look at the "quality of mental illness care available in community settings" (Gater, de Almeida e Sousa, & Barrientos, 1991, p. 761). From these studies several standardized protocols for research were developed for the purposes of cross-cultural application

and validation (Gater et al., 1991). Further to these historical developments, the following current objectives for mental health within WHO are reported:

> Good epidemiological information is needed, information should be collected on systems and activities, data should be collected on concepts of well being, and research programs, tools and protocols should expand across sites (World Health Organization, 2000c).

A clear direction for development of mental health services is constructed by WHO. The direction points to system monitoring, multi-site programs, and assessment tools such as those developed for mental health in the 1990s.

Desjarlais et al. (1995) found that dramatic changes in psychiatric approaches and research, like the developments noted above, have come to form the foundation for restructuring mental illness in a global, multicultural perspective. Classification systems have in turn increasingly become "internationalized" to form a "common language" for psychiatry. The *Diagnostic and Statistical Manual (DSM)* and International Classification of Diseases (ICD) are examples of internationalized instruments for the "advancement" of psychiatry.

Mental health development and the common language of ICD-10. The WHO Program on Mental Health has increasingly focused on the work of standardizing methods for assessment, diagnosis, classification, and nomenclature of mental disorders (Westermeyer, Janca, Sartorius, & Hughes, 1997). The *ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines* (World Health Organization, 1993) is said to represent

> a significant advance towards the achievement of a common language for use by mental health professions worldwide. It has been developed and translated into many languages for different cadres of workers. Training materials, diagnostic instruments and other tools for research and implementation have been compiled to help facilitate the use of the classification. It is said by the working group in charge of the classification tools that precise definitions are necessary if they are to be capable of reliable use across cultures (Westermeyer et al., 1997, p. 3).

A series of lexicons and glossaries have been developed to define the terms used in cross-cultural psychiatry, comparative research, and the application of ICD-10 in various cultural settings. The ICD-10 document contains a cautionary note to the effect that not all professionals will find that the definitions match their local understandings of common terms, but that a "working compromise is essential if a common language is to be established for purposes of communication" (Westermeyer et al., 1997, p. 2).

WHO clearly takes a lead role in conceptualizing mental health and mental illness and its treatments, particularly in areas of the so-called "developing world." Some of the concepts are articulated in strategic plans at the central WHO level, address the identification of target groups (for example epilepsy and depression), and remark on the magnitude of the problems by way of the DALY measure of the "burden of disease" (World Health Organization, 1999). The articulation of such definitions into the diagnostic categories of the ICD-10 (World Health Organization, 1993) is refining the complex task of creating priorities and programs for mental health care globally (Desjarlais et al., 1995). Definitions and central concepts are brought into practice and activated through research that is continuing to develop and advocates a cross-site, standardized approach.

The World Bank

The World Bank and IMF are involved in mental health as well as other aspects of development work that require international assistance and funding. As the primary provider of loans for health services development in poor countries, the World Bank has obvious interests in the efficiency and monitoring of the programs it funds. Standards and guidelines, quality assurance models, particular diagnostic categories, and treatment protocols are of key interest in monitoring and evaluating plans set out by the World Bank. The World Bank lays out clear guidelines, "dos and don'ts," for how mental health services must be organized to qualify for loans. The World Bank guidelines suggest: do create demand by promoting services and providing public education, do improve access to service, do ensure policy and budgets exist that maintain the priority of mental health services, do maintain standards and guidelines, do coordinate access to drugs, and do explore the role of alternative services (World Bank, 2000).

The guidelines are laid out in the interests not only of monitoring the way funds are managed, but also, in the case of mental health care, of promoting broader productivity and economic development. In its guidelines for mental health (World Bank, 2000), the World Bank cites new research (World Health Organization, 2001) that identifies psychiatric disorders as accounting for 12% of the "global burden of disease." This global burden looks specifically at disability and loss of productivity in the labour and consumer markets. Four out of the 10 top causes of disability are reportedly related to mental and neurological disorders. Depression is singled out as increasing; the incidence of depression among women and the alarming loss of productivity in the work environment are noted in World Bank reports. The costs of these mental ill health disabilities and the loss of productivity are manifested in the high service utilization in hospitals and the public health sector (World Bank, 2000).

The World Bank guidelines for mental health, "Mental Health at a Glance" (World Bank, 2000) make several recommendations for managing the loss of productivity and "burden of disease." The World Bank recommends the "development and implementation of standards and guidelines, strengthening of support and supervision of mental health care providers, and the support for development and implementation of mental health management information systems" (World Bank, 2000).

Guidelines and standards. The World Bank directs its debtors towards standards and guidelines so that they will comply with monitoring and evaluation procedures. World Bank guidelines for monitoring and granting loans are clearly in harmony with WHO guidelines. Of particular interest are the notions of developing and implementing mental health management information systems. WHO guidelines, research strategies, and tools have evolved over several years. Such tools as the "Quality Assurance Handbook" and the ICD-10 Classification System can be seen as an example of official standards to which nations must adhere as they are reporting on and seeking loans. Documents that include check-lists and glossaries have been designed through the WHO mental health division by select experts in psychiatry to assist in the development of mental health care quality assurance programs. What WHO standards represent holds authority and is the standard by which the World Bank sets criteria and holds customers accountable. Taking action to improve research and maintaining clear strategies for diagnosis and treatment are two of the many ways quality assurance is checked and measured internationally to ensure accountability (Bertolote, 1994).

The basis of the tools and frameworks, as they are currently activated, consists of the studies that have been built on in Desjarlais et al.'s (1995) text on global mental health concerns. This text is the work of a key group of WHO researchers/directors, academics, and World Bank mental health policymakers, who focus on the "global burden of disease" perspective and the notion of disability-adjusted measurements of productivity in their calls for action. The ICD-10 is taken for granted as the common language of mental health internationally in this text, which has been the foundation of moving the global mental health agenda forward. In my analysis of the discourses on "World Mental Health," I have found that the perspectives are not isolated but rather integrated and connected as a framework for developing mental health and making it actionable and accountable internationally. Finding this weave of conceptualizations and recommendations in the discourses, I have come to call the overall framework the "World Mental Health" framework. This framework, a constellation of mental health conceptualizations of WHO, the World Bank, and academic literature, incorporates the interests of all of these actors in international development.

International Development and Mental Health

In order to "do" accountable mental health work, with research, programs, quality management measures, and assorted other requirements, there are associated financial costs to maintain quality programs and secure loans. WHO estimated in its 2001 annual report that in the United States alone, the yearly cost of depression is US $44 billion, equal to the total cost of all cardiovascular diseases (World Health Organization, 2001). These discursive accounts construct a case that, for poor countries to begin to tackle these issues "properly," they must receive help from the international community. Desjarlais et al. (1995) further the call for assistance, research, official aid, and "political will" directed to developing nations' mental health programs. It is made clear in the discourse that, for poor countries to "do" mental health properly, the international community must be involved.

The international development discourse has traditionally treated development as a "top-down process" (Black, 1991, p. 20). This implies control of decision-making by major donors in centres of established power, and the overlay of technologies and ideologies of modernization from these centres to those that are less "developed." Trickle-down development (Black, 1991; Leys, 1996; Neufeld, 1995; Webster, 1990)—material benefit moving from those who are best positioned to the neediest—is assumed. Stimulating the economy, or "priming the pump" for further economic turns, would be the goal of development in this perspective, and overall enhanced productivity would be considered evidence of betterment. The tendency was (and continues to be) to measure development in monetary terms, with this notion of priming the pump at the centre of development planning.

Development thinking in the 1970s was that human rather than material resources should be the measure of progress. This led to great attention to employment and unemployment as key issues of development throughout the decade (Webster, 1990). In the 1980s, the "bottom up" approach to development came into vogue and called for empowerment, attending to health and education, and locally based problem-solving. As an expression of this more socially conscious approach, new measures for quality of life have become de rigueur (Desjarlais et al., 1995; Walt, 1995; World Health Organization, 1999).

Theorizing about development has evolved since the 1970s, and successful development has come to represent something quite different from economic measurements. Critiques of "modernization theory" and "underdevelopment theory" have framed much of the analysis in the literature (Harrison & Huntington, 2000; Stackhouse, 2000). Some of these trends lead towards looking at how issues of "cultures of poverty" are influencing international development (Harrison & Huntington, 2000). Other trends have us rethink how "local" communities act and how their knowledge brings about technologically appropriate and culturally/environmentally protective development in ways that foreign aid per se ignores (Stackhouse, 2000). There is also critical international development literature that speaks to the corruption of international organizations, aid agencies, and local governments (Hancock, 1989). In particular, new discursive trends in thinking about development issues and the "unsatisfactory progress of humankind towards prosperity and political pluralism" (Harrison & Huntington, 2000, p. xxi) have emerged from a group at the Harvard Academy Symposium. This group has refocused on the role of cultural values and attitudes as either facilitating or constraining particular notions of progress.

An emphasis on enhancing so-called "progress-prone" behaviours, strategies, and attitudes and discouraging "progress-resistant" styles and approaches has evolved (Lindsay, 2000). Though the discourse has taken somewhat different directions, practices in the field have maintained certain top-down features. These general international relations and donor practices are represented in specific health programs, including mental health.

Official aid, which I have come to understand as aid through the grants and loans of the IMF/World Bank, has historically been considered the most effective means of "stimulating development" and stimulating productivity and consumer activity through international relations (Neufeld, 1995). Those in oppressed nations have been encouraged to borrow from institutions like the IMF/World Bank. Other major international agencies distributing aid include the United Nations, the Organisation for Economic Co-operation and Development, the European Union, and the U.S. Agency for International Development. This assistance is said to be preferred to commercial banks or even philanthropic aid, because (in theory):

> It can be used to develop social utilities which might include schools, hospitals and non-commercial establishments; it can be more carefully controlled by officials in the field to ensure funds are received by those it is intended for; it can be obtained by donors in various forms and terms and is considered more flexible a source than private sources and is usually cheaper because of grant offers or interest-free loans (Webster, 1990, p. 151).

Although loans from official sources have been provided at a relatively low cost to oppressed nations, a very large debt burden is a unique feature of the process of development as experienced by those countries being "developed." This burden has been attended by increasing hunger, illness, and poverty. The literature is increasingly permeated by the sense that the current ways of working in development are not successful (Webster, 1990). Many developing mental health services are largely funded through loans from the World Bank, aid agencies, and philanthropic institutions. This lending is, of course, at the price of interest payments and "the interests" of the lender regarding how loaned funds are used. My experiences and those of others in the field (Jakubec, 2001; Jakubec & Campbell, 2003; BasicNeeds, 2003) demonstrate these discourses at work.

Western aid programs are selective in that most support countries that are friendly to Western free-market interests and Western ideals of modernization and progress (Neufeld, 1995). In many cases, they support countries that agree to purchase products and standards from the donor, a practice that in international development discourses is referred to as aid tying (Canadian International Development Agency, 2001). This practice represents one of the many activities of globalization that have an impact on mental health and development. In Canadian food aid loans, 90% of the loan is tied back to the purchase of Canadian goods (Canadian International Development Agency, 2001). Health care–focused loans would similarly be tied to the donor county's medical/pharmaceutical goods and services. The costs to poor nations are great: developing countries may pay an average of 15% to 30% more for goods and services under tied-aid requirements.

Loans and the "Common Language" of Basic Need

The concept of *basic need* is woven into the discourses of the "World Mental Health" framework. Mental health services and research directions are described as "inclusive" of basic needs, or needs that are considered universal and priorities for development. Some of these directions are illustrated in the development and mental health discourses as: governance, peace, improving multi-lateral effectiveness (Canadian International Development Agency, 2001), and other supposed routes to political safety, productivity, and enriched economies. Western interests, economic measures, and modernization have come to be represented in the "common language" and discourses in international relations and development work, including the "basic need" discourse. Donors (or lenders like the World Bank) have become pre-occupied with aid towards economic reform and political stabilization in the name of meeting "basic needs," while further emphasizing tied aid and Western-oriented trade negotiations.

According to Desjarlais et al. (1995), mental health frameworks have connected with the generalized basic need discourses over the last several years. The definitive "call for action" has been set out and suggests that, while great strides have been made in developing mental health services and research, new technologies, methodologies, and treatments must be adapted for use across diverse cultural settings (presumably to advance the care of the mentally ill quickly and efficiently, and to ensure particular modes of treatment and product delivery). These actions, it is said, must be "inclusive" and not be constrained by the circumstances of poverty, violence, displacement, and other health problems that connect to "World Mental Health" (Desjarlais et al., 1995).

A CONCEPTUAL FRAME IN ACTION

The World Assembly for Mental Health, Vancouver, 2001

In July 2001 the World Assembly for Mental Health was organized by the World Federation for Mental Health (WFMH), an organization in official consultative status to the United Nations. At this event, collaborators in "World Mental Health" converged and the framework was made visible to me. The framework that ties WHO, the World Bank, and the WFMH together to understand and promote action for mental health services became a "social fact," or common sense.

The work of advancing the "World Mental Health" discourse is done at conferences such as this. Speakers from a variety of sectors (health, banking, inter-

national development, academia, bio-technologies, and other corporations like publishers) were present, used its language, spoke from shared assumptions that I have described previously in this paper, and worked to activate the framework discursively. Activating the framework allowed those in attendance to hear research from the health sector crossing over into the talk of the World Bank and vice versa. It is of note that the cross-over of these sectors (particularly the influence of the biotechnology and pharmaceutical industries in the "World Mental Health" framework) was heavily protested by consumer/user groups and anti-globalization activists. Overall, the "burden of disease" and economic discourses of the World Bank weighed heavily on the discussions at this international conference. Especially singled out for critique by mental health service users was the view of aid being allocated by "burden of disease" and the World Bank's involvement in mental health funding.

In his opening address, Dr. Marten deVries, secretary general of the WFMH, called for practitioners to "reorient ourselves to the new epidemiological and cost factors of mental health services" (DeVries, 2001). This reorientation, he suggested, should be based on a "science of sustainability." Within his address the discourses of classification of disease, productivity, "global burden of disease," and DALYs were clear. Dr. P.H. Barret, president of the Canadian Medical Association, also spoke of the statistics of the "burden of disease," the ever-increasing magnitude of the problems of mental ill health, and the corresponding economic burdens. He spoke to the important role of physicians, calling for increased "standards," consensus on strategies, and the development of research capacity.

WFMH President Dr. Ahmed Abdou El Azayem spoke of the "two-way relationship" of the UN/WHO and non-governmental organizations (El Azayem, 2001). He highlighted the importance of fostering a science base and improving standards and monitoring in legislation, policy, diagnosis, and treatment. He called for the establishment of clear protocols for the management of psychiatric disorders, quantifiable diagnostic measurements, and corresponding drug treatment protocols, paradoxically reinforcing a standardized and largely unsustainable Western orientation to mental health care.

Florence Babgaba, specialist with the World Bank in Public Policy and Mental Health, spoke on the bank's perspective (Babgaba, 2001). In her speech Babgaba did not try to conceal the World Bank's mandate, but spoke about it as "a lending institute, whose partners are client countries and whose mission is to alleviate poverty." Studies looking at cost-effectiveness of psychosocial interventions were referred to as the "productivity of the World Bank." She described the production of a mental health fact sheet and numerous meetings in the vein of "social capital and mental health" and "mental health financing." These fact sheets address the World Bank's plans for measuring disability, mental health, and work. Her concluding remarks were words of advice about the importance of monitoring and evaluation (or addressing "input, process, and output"). She spoke of the need for evidence of effective (and specifically "cost-effective") interventions that are applicable to developing countries. Babgaba suggested that interventions "can reverse the dysfunction, thus leading to increased productivity and economic development".

Dr. Rachel Jenkins, psychiatrist with the WHO Collaborating Centre in London, spoke about getting mental health into public policy (Jenkins, 2001). Cautioning that DALYs do not include "everything," she suggested that the situations are very different, and although similar issues do exist country to country, locally tailored solutions are important. She also stated that there needs to be increased access to an

international evidence base, specifically recommending epidemiological methods. Jenkins further noted that WHO had lobbied for developing countries to have internet access to professional medical journals. Professional journals are another vehicle for the distribution of knowledge. Putting dominant Western knowledge at the fingertips of readers in developing countries further reinforces a particular kind of knowledge development internationally, again in contradiction to locally tailored knowledge development. Also in contradiction to the locally tailored approaches she promoted, Dr. Jenkins and WHO report on the importance of integration via training and guidelines, specifically the ICD-10, and corresponding essential prescribing.

Global responses and interpretive frames (Western, scientific, psychiatric, and pharmacological in orientation) were clearly promoted throughout the World Assembly for Mental Health. The "World Mental Health" discourse was visible, but taken for granted as "fact" and a benefit throughout the event. I was able to see how the dominance of the framework is largely unquestioned and how I, as a practitioner and development worker, enter into the discourses, using the globalized terminology in program and research work internationally.

Mental Health and Development to Enhance Productivity

In the World Assembly for Mental Health, representatives of WHO, the World Bank, and the WFMH repeated the message that mental health development and progress are accomplished, among other ways, through highly standardized research programs, numerous special "mental health days," and other quality management tasks. The ever increasing number of nations complying and organizing within the targets and frameworks set out by WHO, the World Bank, and the WFMH also demonstrates an advancement of mental health according to these experts. In these messages, it can be seen that mental health development is strongly linked to international development through the "World Mental Health" framework, in which mental health problems are named as burdens to productivity and capitalist society. Standardized treatments and research are strongly encouraged as the response to these burdens.

An interesting aspect of the conceptualizations and implementation strategies of the global view of mental health is that these concepts are part of an organizational framework. This is a framework that manages and surveys the use of resources throughout the world; it is, in Smith's (1990a) terms, a "ruling organization." I saw the interconnection of the research agendas, themes, and discourses at the World Assembly for Mental Health. The social relations involved in mental health research are indeed complex and organized but also highly invisible. Social relations aimed at producing and meeting individual and community needs as set out in the global mental health framework, rather than concentrating on building local relationships, assets, and capacities (Kretzmann & McKnight, 1993), will forever require expanding demands for more funding, maintaining activities of domination and dependency. Uncovering these discourses on "World Mental Health and Development" makes visible some of the interconnection and complexity of the cycles of domination and subordination. The discourses of "World Mental Health" have a programmatic sequencing of actions that works actively with and through local practices. Through specific inquiry that can illuminate the way official discourse leaves out local relevancies and actualities, we can begin to understand some of the reach of the globalization of "World Mental Health."

Many scholars are recognizing the need for a decidedly different kind of scholarship in the era of globalization, one that investigates the control exerted by dominant powers through dominant discourses (Ilcan & Phillips, in press; Farmer, 2003). The contradictions and conundrums of proceeding with meeting the needs of the many people who require mental health care in the developing world requires that we investigate the exercise of current "basic need" and "health as a human right" discourses to assist us our rediscovery of people's actual experiences. There are certainly many contradictions in providing for basic needs, human rights, and mental health care. Farmer (2003) and other critical community health scholars are speaking to these conundrums. States Farmer:

> Exposing such constrictions calls for critical scholarship . . . Ivory-tower engagement with health and human rights can reduce us to seminar-room warriors. At worst, we stand revealed as the hypocrites that our critics in many parts of the world have not hesitated to call us (p. 224).

Through connecting the development and mental health discourses, we can see how experiences of domination are constructed and, often inadvertently, acted on by well-meaning practitioners. This exploration has illuminated some of the ways we as practitioners get trapped in the rhetoric and ways of knowing as organized from dominant perspectives, even in the face of experiences of everyday life working in mental health and development.

Getting beyond the rhetoric is necessary if we are to do more than the work of "seminar-room warriors." This paper has examined the puzzling dominant discourses in mental health and development and in doing so allows us as researchers and practitioners to step outside ways of knowing that cloud our everyday experiences with slogans, rhetoric, and taken-for-granted knowledge of mental health and development. The analysis has brought me an awareness of the discourses and processes that organize the settings in which I work. This consciousness has allowed me to experience different standpoints from those I can easily find myself trapped in as one who is from a privileged nation and is schooled in the professional discourses of "World Mental Health" and "international development." I have explored how the ruling practices of "World Mental Health" happen in the knowledge practices of international conferences and the distribution of surveys, clinical tools, and pharmaceutical technologies. I have seen how this occurs in research and clinical practice, as a generalizable feature of capitalism in our increasingly globalized world.

DISCUSSION

My experience as a mental health nurse in West Africa allowed me to see that the call in the international development sector for improved standardization, management, monitoring, and order has been brought to bear on my work in the development of mental health through ideological practices (Jakubec, 2001; Jakubec & Campbell, 2003). Through analysis of the conceptual framework for mental health and development as it was activated at the World Assembly for Mental Health, I have been able to trace how calls for standardization, monitoring, and evaluation operate in concert with the requirements of the primary funding agency (the World Bank) in poor countries. Coordinating, standardizing mechanisms (specifically the ICD-10) have a home traceable to the WHO and World Bank development and mental health discourses, which constitute what I call the "World Mental Health" framework. As practitioners in international mental health and development, we are necessarily

brought within the discursive organization of this framework and need to be critical of the discourses we take for granted in our everyday practices.

By explicating conceptual frames enacted in current discursive practices in mental health and development, I have made many issues and ruling practices visible. Issues of time, efficiency, delays, symptom categorization, and standardized treatment practices that are visible in the texts have as their origins the "World Mental Health" conceptual frame. In seeing the framework I can question whether or not that is how these issues were understood on the ground and whether the discourse is assisting or interrupting actual mental health and development.

I suggest that this cross-cultural psychiatric globalization effort operates as part of a ruling regime. I argue through and beyond this explication (Jakubec, 2001; Jakubec & Campbell, 2003) that the capitalist enterprise is at work in the subordination of local practices and in the mass marketing of the tools of the ruling regime (namely the ICD-10 and resultant biomedical treatment strategies) in the assumed benefit of the dominant discourse of mental health and development. The growth and expansion of the pharmaceutical industry's market world-wide is a testament to this dominant ideological evangelization. The production and activation of the "World Mental Health" framework includes an emphasis on "mental illness" policy rather than "mental health" in all its local relevancies. In seeking to meet individual and community needs, global mental health and development actors will forever be entrapped in meeting constructed needs, needs that cannot be maintained with local and sustainable solutions and require significant aid, globalized solutions, and the products of a capitalist enterprise. The actors in this social relation of domination are progressively accepting this "prescribed" progress as an unquestioned reality.

CONCLUSIONS AND IMPLICATIONS

It is clear that a general conceptual framework of "World Mental Health" is expressed by the official expert knowledge of WHO (World Health Organization, 1999) and other organizations (World Bank, 2004). Some of the concepts articulated in strategic plans at the central WHO level address the identification of target groups (for example, epilepsy and depression) and remark on the magnitude of the problems by way of the DALY measure of the "burden of disease" (World Health Organization, 1999). The articulation of such definitions into the diagnostic categories of the ICD-10 (World Health Organization, 1993) is refining the complex task of creating priorities and programs for mental health care globally (Desjarlais et al., 1995). Definitions and central concepts are brought into practice and activated through research that is continuing to develop and calls for a cross-site, standardized approach. The conceptualizations and methods of implementation of the global view of mental health are, indeed, part of an organizational framework. This is a framework that manages and surveys the use of resources throughout the world; it is, in Smith's (1990a) terms, a "ruling organization."

The ruling organizations of the "World Mental Health" framework have a programmatic sequencing of actions that subordinates local practices to Western priorities (e.g., the disease and treatment models that will be funded, the kinds of training experiences that will be legitimated, research priorities and program models that will be designed). I have experienced this subordination as a practice that both facilitates and constrains the sustainability of support to local mental health services. Indeed, there are aspects of the ruling regime of WHO's mental health division,

research agendas, and processes of standardization that I see as enormously beneficial to practice. There are also aspects of the regime that fail to explore local interests while taking for granted dominant discourses as "right," legitimate, factual, and helpful. Paradoxically, a disorganization of practice occurs when the global discourse stands in for local realities. As researchers and practitioners, we are called to problematize the "World Mental Health" framework and the discursive practices that render invisible alternative conceptions to the globalized mental health discourse and the attendant interests of economic globalization.

RÉSUMÉ

Cet article présente une étude d'un discours dominant de « La santé mentale mondiale » qui s'inspire des expériences et des recherches en santé mentale et en développement international. Cette étude analytique offre un point de départ pour l'examen des critiques et des hypothèses actuelles de l'idéologie mondiale en santé mentale. Afin de bien comprendre le domaine tel qu'il est organisé de manière sociale (Smith, 1987, 1990a, 1999), on doit examiner la position discursive qu'occupe l'idéologie de « La santé mentale mondiale » dans le cadre des efforts globaux pour la réduction de la pauvreté et le développement de la productivité capitaliste et du commerce. En explorant les discours internationaux actuels, je soutiens qu'il est possible de redécouvrir la réalité locale alors que les chercheurs développent et partagent leurs connaissances puisées au-delà de ces discours dominants.

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