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TITLE

Poles Apart: does the export of mental health expertise from the Global North to the Global South represent a neutral relocation of knowledge and practice?

ABSTRACT

The World Health Organization's *Mental Health Action Plan 2013-2020* identifies actions for all member states to alleviate the global burden of mental ill health, including an obligation for mental healthcare to be delivered in a 'culturally appropriate' manner. In this paper we argue that such a requirement is problematic, not least because such pronouncements remain framed by the normative prepositions of Western medical and psychological practice and their associated ethical, legal and institutional standpoints. As such, when striving to export Western mental health expertise, different paradigms for evidence will be necessary to deliver locally meaningful interventions to low and middle income countries. Our discussion highlights a number of philosophical concerns regarding methodologies for future research practice, including those relating to representation and exclusion in the guise of epistemic injury, presumptive methodologies arising from Western notions of selfhood, and related ethical issues.

KEYWORDS World Health Organization; mental health; global health; recovery; epistemic justice

INTRODUCTION

The export of Western mental health expertise to non-Western contexts is both challenging and problematic, not least because the knowledge and practices it describes arise from and

continue to evolve within an array of Western ethical, legal and institutional standpoints. In this paper, we discuss and develop two key points: how Western suppositions about mental well-being may not fit into cultural contexts that are not subject to Western user/consumer discourses, and how evidence based practice might be reconceived to better represent local needs and provide a degree of protection from the disciplinary power of Western psychiatry.

The World Health Organization's (WHO) *Mental Health Action Plan (MHAP) 2013-2020* (WHO 2013) identifies actions for all member states to alleviate the global burden of mental ill health, with the principal aim of developing of mental health policy and promoting improvements in mental health practice and service delivery (WHO 2008, Funk *et al.* 2010). The WHO's objective is to encourage its member states to develop mental health policies and legislation, and to improve access to treatment and human rights for people with mental health problems. In low and middle income countries (LMICs), the WHO seeks, through its *Mental Health Gap Action Programme* (WHO 2008), to mirror a trend in high income countries (HICs) whereby resources are reallocated from centrally-managed institutions to community-based services.

The WHO Action Plan

The *Mental Health Action Plan 2013-2020* (MHAP) recognises the social, political and environmental determinants of mental wellbeing, including poverty, disability, social, and gender inequalities, war and natural disaster. Its objectives span prevention, treatment, rehabilitation and recovery under six principles, namely: universal coverage, human rights, evidence based practice, life-course needs, multi-sectoral responses and service user empowerment. However, although the MHAP indicates that mental health care should be 'culturally-appropriate' (WHO 2013:9), we argue this pronouncement remains framed by

normative prepositions of medical and psychological practice that are essentially ‘Western’ with regard to their polities, cultural norms and notions of personhood (for instance, an individualistic, liberal-democratic character). Such norms and notions are arguably most associated with the ‘historically industrialized and urbanized’ (Pike *et al* 2014:21) countries of the Global North, although we also note that in the context of globalization these conventions of nomenclature remain subject to debate (for instance, Pike *et al* 2014:22-23).

The MHAP incorporates concepts of illness, aberration and disability, as understood within HICs, whilst simultaneously presupposing that the predominant Western notions of human rights, capacity and insight, and the practise of freedom, selfhood and normalcy in the Global North, are readily transferable to mental health practice within the diverse cultural contexts of the Global South. Additionally, the MHAP emphasises practices such as community partnership working and user ‘empowerment’, which may incite the export of Westernized mental health recovery practices from HICs in the Global North to the LMICs of the Global South. We see this as problematic where notions of the individual, mental distress and expert authority are culturally distinct from Westernised societies.

The WHO is critiqued for acting as an ‘uncritical articulator’ (Summerfield 2012:10) of bio-medical mental health, by assuming the superiority of the Western approach within the MHAP and relying on the established psychiatric institutions in the United Kingdom and United States. Psychiatry itself is critiqued in the global context for still adhering to bio-medical solutions in the face of environmental determinants of distress such as poverty, social inequalities and injustice (Campbell and Burgess 2012), while the evidential epistemologies that support the North’s Westernised mental health interventions are based on cultural norms quite different to communities in the global South (Fernando 2012a). Developing the earlier

arguments of Said (1993), Summerfield (2012) views the dominant Western construction of psychiatry as ‘medical imperialism’ which, as modern colonialism, seeks to educate, modernise and civilise others (Summerfield 2012:525). Indeed, Mills (2014) identifies global mental health as a colonial discourse itself, in which NGOs facilitate delivery of the language and concepts of Western mental health via the techniques of diagnostic classification of mental illnesses.

Problematising Western mental health

In the modern epoch, the human mind has become a principal subject for political, moral and institutional discourse; to have an atypical mind or sensibility has become a *recognisable*, if not always desirable, way in which individuals can become ‘known’ to others in the contemporary West (see Hacking 2007). It is in this way that the individual can become subject to classification by knowledgeable agents; a person can, for instance, become *knowable* as one who is ‘depressed’, or ‘schizophrenic’, and with skilled intervention and, not least, significant personal effort, might be one who can be restored to normalcy, or palliated in some other way. This stands in contrast to earlier epochs, where what today is understood (and therefore knowable) as a ‘mental health concern’ might have been described, named and responded to quite differently, for instance in terms of criminality or aberrant spirituality (see Szasz 1960, Foucault 1981).

As such, the contemporary Western notion of mental ‘well-being’ is arguably underwritten by medical (bio-psychiatric) and legal (ethical) discourses that both fashion the atypical subjects they describe, and authorise the means by which they may be classified and best managed. For instance, the WHO’s definition of ‘mental disorders’ embraces the 10th *International Statistical Classification of Diseases and Related Health Problems*, or ICD-10

(WHO 1990) which typifies the manner in which mental ill-health is rendered classifiable and diagnosable. Hence, schizophrenia, depression or intellectual disabilities become ways in which people may be classified.

The ICD-10 and the American Psychiatric Association's *5th Diagnostic and Statistical Manual* (DSM-5) (APA 2013) classification schemes have been deemed problematic by some observers. For instance, Wildeman (2013) describes the imposition of bio-psychiatric classifications as 'the shrinking of the normal' (Wildeman 2013:50), expanding the boundary of pathology, increasing the role of the pharmacological industry, and furthering the exportation of a professionally-prescribed 'disease model' for mental health; this, she argues:

“... risks reinforcing the sceptical critique that, despite the best of intentions, both global mental health policy and the international human rights model ... are liable to function less to enhance human well-being within a framework of respect for diversity than to expand professional power along with the global capitalist/pharmaceutical markets within which professional power is inscribed” (Wildeman 2013:52)

The DSM and the ICD systems of clustering symptoms into disease categories premise a biological basis for specific classifications, and reinforce the notion of diagnosable 'illness', yet some have argued that the DSM system is more convenient than scientific. For instance, the DSM is defended on the basis that wider choice allows more flexibility in the context of electronic record keeping (where forced choice selections are required) (Berger 2013). The expansion of DSM also includes stress 'disorders', arguably legitimising a person's 'condition' and so justifying access to formalised help (Brewin 2013). Furthermore, institutional agencies have also been critical: for instance, the US National Institute of Mental

Health (NIMH) recently rejected the DSM-5, representing, perhaps, an emerging ‘crisis’ in Western psychiatry constituted by a split between the ‘orthodox-scientific’ (e.g. ‘evidence-based’, bio-psychiatric pharmacological intervention) and ‘psycho-social’ paradigms of psychiatry (Thomas 2013).

Specific criticisms, such as those above, reflect a long-standing argument in the West that psychiatry does not (or cannot) mirror the diagnostic precision of the more ‘physiological’ fields of medicine; or, as Wyatt and Midkiff suggest, bio-psychiatry is ‘a practice in search of a science’ (Wyatt and Midkiff 2006:132). Moncrieff (2007) suggests that (Western) psychiatry has become bound to a disease model, relying on medication instead of working collaboratively with the patient, with knowledge of his or her (social) situation, to alleviate symptoms. Indeed, the turn toward psychosocial, person-centred approaches to mental wellbeing in the West demonstrates recognition of the importance of inter- and extra-individual factors such as the availability of employment, family support and social inclusion to mental well-being (Mueser *et al.* 2013).

Summerfield’s notion of ‘medical imperialism’ (Summerfield 2012:525) problematizes the transfer of concepts associated with (mental) distress between different cultural environs. More recent experience following the 2011 tsunami in Japan serves to illustrate how Western and non-Western discourses of mental wellbeing may be managed, both incorporating the Western concept of ‘mentally ill’. In an interview with a Buddhist priest in Japan, Khan (2014) reports a phenomenon whereby sightings of, and possession by, the spirits of people killed were made by survivors; explaining his supportive role, the priest recounted one survivor possessed of ‘several different’ spirits:

“It took me three months to cure her [...] I gave these spirits counselling, and convinced them to go back to where they belong ... people [here] are very religious, and perhaps think of spirits as equal to living people [...] I believed that she was not mentally ill” (Khan 2014, broadcast interview)

Here, the priest uses ‘cure’ and ‘counselling’ (terms that are themselves subject to the interpretation made by Khan’s translator) but defines the phenomenon in a culturally-specific understanding, separating this from ‘mental illness’ and the need for (Western) intervention. There appears a division of the two concepts and a choice to be made: to meet the cultural need with what appears to be a traditional (Buddhist) practice (see Keng *et al* 2011), and a possibility of a ‘mental illness’ needing, perhaps, medication. This perhaps illustrates that more nuanced approaches to mental health intervention may be more fitting in contexts where cultural knowledge and practices associated with sustaining ‘mental and social wellbeing’ are already extant; it follows that the WHO should be developing mental health interventions in non-Western contexts which acknowledge local knowledge and practices associated with mental wellbeing rather than emphasising (and imposing) Westernised practices of diagnosis, therapy and/or pharmaceutical intervention.

Beyond psychiatric pathologies

Complex health challenges such as obesity in HICs has shifted public health attention toward the nexus of disease/agent and socio-economic environment, and this finds manifest expression in policies of localism, user/consumer centred involvement, and community engagement. Factors of social inclusion, citizen authority and community resilience stimulate methodologies which strive to explore and discover how communities and their members can be incited to act authoritatively, or how they are barred and disenfranchised from

participation. In HICs, such challenges are being met with networking and collaborative approaches such as co-productive and participant action research, which reveals epistemological, in addition to practical and methodological challenges; who defines ‘community’, ‘inclusion’, ‘authority’, and ‘who’ remains ‘invisible’ (Conroy *et al.* 2013).

These approaches go some way to addressing locally- and community-embedded factors for wellbeing, but also demonstrate the epistemic and methodological challenges faced by (Western) researchers when working with ‘ground-up’ actions and their ‘local’ perspective in non-Western cultural contexts. For instance, following the 2004 tsunami, Western counsellors providing international aid found fewer than expected symptoms of post-traumatic stress disorder among Sri Lankan victims, but higher levels of distress associated with their loss of social role after the disaster (Fernando 2012b). Fernando attributes this to the greater *social* nature of identity in the culture. Similarly, McGruder (1999) describes the emergence of high-expressed emotion among mentally distressed Tanzanians following exposure to Western psychiatry; this occurred within a culture in which ‘not speaking’ was the more common response to stress. Such evidence exposes the *epistemic risks* inherent when imposing Western methodologies upon LMIC contexts and populations, and suggests that healthcare interventions will need to be based upon knowledge of *local* culture and practices in order to deliver meaningful and efficacious responses to local issues.

The export of the Western psychological self

The notion of mental ‘well-being’ can be understood to be an artefact of Western, post-enlightenment discourse and the concern for and privileging of individual subjectivity and its pathologies. This is not to say that the ‘problems’ diagnosed or experienced are not ‘real’ to those concerned, but rather that they are individual (and social) experiences that are rendered

‘knowable’ (and hence classifiable) by the extant Western discourses of medicine, psychiatry and psychology. Indeed, within his Foucault-inspired thesis on ‘making up people’, Hacking (2007) shows how scientific, medical and psychological classifications can ‘bring into being a new kind of person, conceived of and experienced as a way to be a person’ (Hacking 2007:285); that is, not only can certain ‘kinds’ of people become *knowable* to mental health experts, but that individuals can come to recognise *themselves* as such.

In a similar vein, as Rose and colleagues have shown in over two decades of analysis, to ‘know oneself’ as a psychological subject is perhaps an *obligation* in the Western present (Rose 1998:32, Rose 1999, Rose *et al.* 2006), and it is in this way that we might understand how mental well-being in HICs is becoming increasingly devolved to institutions and the citizenry; populations are governed through the professions and the incitement of people to act on their ‘selves’ in particular ways. Described by Foucault in his concept of governmentality (Foucault 1997), this means that the (modern) state, instead of governing populations through forceful intervention, attains knowledge of its population and disperses governing techniques via a number of disciplines and their experts (Foucault 1995, Rose 1998, 1999, Rose *et al.* 2006, Hacking 2007). This disaggregation of power and its dispersal to individual subjects effects their administration from a distance, thereby inciting their agency: the individual is obliged to act by and for one’s self, and in doing so, ‘produce the ends of government’ (Rose *et al.* 2006:89).

In the Westernised Global North, psychological self-sufficiency is accorded considerable privilege (Rose 1998, 1999), and how one can ‘be’ is described (and ascribed) by psychological knowledge and its schemes of classification; for example, one can be known (or come to know oneself) as ‘depressed’ or ‘emotionally-intelligent’. These classifications

are how individuals come to know and recognise one-another, both within and outside the confines of expert disciplinary practise. These ‘ways to be’ a person dovetail with the obligations of Western life, and may be understood as correlates of success or failure. It is within this particular discursive context that Western mental health practice is meaningfully sustained and, as such, may not be sustainable (or even meaningful) outside its environs.

In non-Western (and rural) cultures, the capacity ‘to know’ may be possessed by authoritative members of the community. For instance, the nomadic *Himba* peoples of North West Namibia invest the elders of their community with the authority and duty to adjudicate on matters of well-being (Lesch 2013) that, unlike much of the West, are undifferentiated in terms of social, physical or mental health. As such, the WHO’s recognition of the need to work with community leaders as ‘gatekeepers’ may be more than just expedient; such leaders may also have an important role to play in the understanding of ‘problems and solutions’ as they might (or might not) apply to their local communities.

Lessons already learned in High Income Countries

An argument for developing Westernised psychiatric approaches within LMICs is that recognition of certain mental states as ‘illness’ confers legal and moral protection to sufferers and permits standardised treatment (Kleinman 2013). Mental illness management in some LMICs has been considered by some to be inhumane and cruel (Kleinman 2009); it may be argued that the Global North has ‘learned lessons’ in developing its own moral relationship with mental distress and, as such, might be positioned to export its experiences for the benefit of the Global South. However, this supposes that the Western approach is humane and always attentive to human rights of service users. In 2013, the UK mental health charity MIND

reported that over 3000 incidents of face-down physical restraint occurred in English NHS mental health settings during 2011-2012 (MIND 2013), demonstrating that inhumane treatment continues in the Global North.

There have, however, been historical improvements in human rights along the course of Western mental health practice. The incarceration and inhumane behavioural treatments of the 18th and 19th centuries in Europe and the USA were followed in the 20th century by wholesale pre-frontal lobotomies (leucotomies), multiple electroshocks and testing of so-called 'anti-psychotics' on unwilling patients (Whitaker 2002). It is now recognised that outmoded tranquilizers such as chlorpromazine and haloperidol carry high risks of debilitating side-effects such as tardive dyskinesia, akathisia (movement disorders) and hyperprolactinaemia (causing sexual dysfunction) (Taylor *et al.* 2009). Longitudinal evidence demonstrates these medications increase risk of relapse (Bockoven and Soloman 1975, Rappaport *et al.* 1978), while long-term use of second-generation drugs raises the risk of physical illnesses and shortened life expectancy (Casey *et al.* 2011, Wildgust *et al.* 2010, Chang *et al.* 2011, Thornicroft 2011). It is evidenced that institutionalised medical 'care' for major mental illnesses constructs 'madness' and maintains 'patients' in the sick role of 'mentally ill', inflicting iatrogenic, long-term disability and pessimism (Goffman 1959, Rosenhan 1973, Estroff 1981). It is also argued that classification of mental illnesses reinforces the constructs of pathology, given credence by systems such as the DSM and ICD (Benthall 2004), empowering psychiatry, increasing treatment with medication, and fuelling the growth of the pharmaceutical industry (Moncrief 2007).

A growing body of evidence points to only limited short-term effectiveness of anti-psychotic medication, in comparison with the long-term recovery of people not receiving medications

(Rappoport *et al.* 1978, Bola and Mosher 2003, Harrow *et al.* 2012). Several population studies show that patients in LMICs, with limited access to medications, demonstrate better long-term recovery rates than HIC patients who receive specialist psychiatric care but are socially disabled by being in contact with mental health services (Jablensky *et al.* 1992, Harrison *et al.* 2001). In HICs, long-term studies of de-institutionalised community patient cohorts indicate good recovery when patients' conditions are no longer masked by institutionalisation (Harding *et al.* 1987, Harrison *et al.* 2001).

Thomas (2013) and Webb (2012) argue that reliance on technological (Thomas) and empirically driven (Webb) psychiatry has failed to explain mental illness as a disease, and failed to produce meaningful recovery. Instead, evidence points to mental distress as being more context dependent than biologically dependent. A review of evidence by Bracken *et al.* (2012) indicates that medical approaches do not help patients achieve a recovery which is meaningful to them or their society. Bracken *et al.* (2012) suggest that most progress in psychiatry is made when psychosocial factors have been addressed such as empowerment and social inclusion, rather than improvements in psychopharmacology. They detail several modern studies which indicate little difference between drug or ECT (electroconvulsive therapy) treatment and placebo effectiveness (for example, Andrews 2001, Fournier *et al.* 2010, Read and Bentall 2010). Indeed, Moerman (2002) points out that a placebo effect in itself demonstrates that context, culture and beliefs are significant factors in recovery.

It may also be that the working relationship between client and therapist may be as important in recovery as the treatment modality (Frank and Gunderson 1990, Castonguay and Beutler 2006, Bracken *et al.* 2012). Indeed, Stiles *et al.* (2008) argue that if the therapist and context effects were included in research – instead of being controlled as a confounding variable –

such evidence might indicate that therapist effects are *more* likely to deliver treatment effectiveness than medication; indeed, such evidence might support the argument, made above (the Buddhist priest, the *Himba* elder), that the (Western) practice of ‘therapy’ may be subject to purposeful translation and incorporation into non-Western contexts.

Recovery and the ‘survivor’ movement: exemplifying some concerns

The debate over DSM-5 notwithstanding, it appears clear that a philosophical transformation is affecting health care provision within Europe, Australasia and the US, marked by a turn towards ‘user enfranchisement’ and the ‘recovery movement’ in mental health. Driven by government policy (for example, Mental Health Commission 1998, Department of Health 2001, President’s New Freedom Commission 2003), mental health services are adopting recovery-oriented services, tools and protocols (for example, Corrigan *et al.* 1999, Repper and Perkins 2003, Andresen *et al.* 2003) whilst, simultaneously, public health approaches increasingly recognise societal and community influences on health such as community-level cohesion, resilience and adaptation (Elliott *et al.* 2013).

It has been argued that the notion of ‘recovery’ arose from the psychiatric ‘survivor’ movement in the US (Resnick and Rosenheck 2006); the style ‘survivor’ not only being suggestive of the individual who has recovered *from* mental illness, but – more critically – as a collective of people who identify themselves as being survivors *of* care (Diamond 2013). As such, the recovery ‘movement’ arguably represents the manifestation of survivor and user enfranchisement, where emphasis is placed upon a meaningful life even in the presence of symptoms, focusing on ‘strengths’ rather than (psychiatric) ‘deficits’. Indeed, the very symptoms seen as ‘pathological’ in psychiatry might be interpreted either as a gift, or as a spiritual experience (Hearing Voices Network 2014). Read (2012) reports an anthropological

study in rural Ghana, in which biomedical treatment meant little to its recipients. As ‘psychotic symptoms’ persisted, these were therefore interpreted as spiritual experiences rather than markers of ‘disease’; side effects were deemed to be those experiences that impacted on social functioning, including being able to work. Meaningful recovery in this context was, as such, being able to labour, rather than being ‘cured’ of a disease entity.

In this sense, the individual’s experience of ‘being well’, does not inevitably accord with an amelioration or absence of medical (psychiatric) symptoms. In Western cultures, support for someone ‘in recovery’ emphasises social inclusion, self-empowerment, hope and self-development (Jacobsen and Greenley 2001). As such, a lesser emphasis is placed upon individual deficits whilst a greater emphasis is placed upon connectedness with their community or other networks of support. This non-pathological standpoint serves to problematise expert (medical) authority and convention by questioning the basis of its evidential (positivist, scientific) authority (Summerfield 2008) and its associated empirical methods (Thomas *et al.* 2012); research and practices that are styled as ‘community-focused’ or ‘participant-led’ perhaps exemplify this.

Recovery discourses describe what it is to possess ‘good’ mental health, and in the Global North these are understood to cohere with the demands of Western psychiatry: to be resilient (not pliable), adaptable (not merely flexible) and, most of all, a skilled consumer of ‘care services’. As such, these new forms of personhood do not ‘resist’ the hegemonic power of psychiatry; rather, they imbricate within it new ‘ways to be a person’, albeit in the context of Western liberal society. As such, the Westernized orientation towards ‘the self’ - one’s individual strengths and deficits - would appear to diminish the individual’s reliance upon their host community. However, the notion (and practice) of ‘recovery’ in the West may be

problematized: we argue here that recovery is enmeshed within a neoliberal context that incites individuals to accept responsibility for their own (mental) health (Rose *et al* 2006, above). Moreover, by positioning recovery ‘within’ the individual, social factors such as inequality (Harper and Speed 2012) may not be recognised fully. In addition, recovery ‘reframes deficits as strengths’ (Harper and Speed 2012:9), that is, despite their new status as a person ‘in recovery’, the individual nonetheless remains defined in relation to that which they are deemed to be recovering *from*.

In contrast, within communities not dominated by cultures of individualism, recovery practice may combine with locally pertinent knowledge and sensitivities. For example, among Aboriginal Peoples in Canada, identity and mental resilience appears embedded in a collective cultural history and the natural environment, with personhood strengthened by the transmission of culture through storytelling, language and ritual (Kirmayer *et al.* 2011). Similarly, Mohatt *et al* (2008) describe story-telling in Alaska-Native (AN) communities in the context of reducing alcohol dependence; their analysis shows that although ‘recovery’ is practised in a manner analogous to that of mindfulness (as reinterpreted in the West), it also possesses a distinct, local, character with regard to the importance of kinship and the natural environment. The inference to be made from both examples is that identity in such locales is *ecocentric* rather than *egocentric*. As such, practitioners from HICs need to be mindful of extant cultural ecologies and their role in abating (mental health) problems which are, ostensibly, ‘Western’ in character and aetiology.

Seeking methodologies: some priorities for theory and practice

The World Health Organization lists evidence-based practice (EBP) as one of its principles. Many argue that EBP, as currently understood and practised, is a technology of power for

Western medicine. For instance, Griffiths (2005) and Lambert (2006) argue that EBP is a tool in power relations; that is, the exercise of evidence production (knowledge) is simultaneous with the exercise of professional power (see Foucault 1997, *passim*). Furthermore, evidence-based practice disempowers the patient and individual clinician and empowers the medical corporate institution (Mykhalovskiy and Weir, 2004, Freshwater and Rolfe, 2004). For Lambert (2006), a hierarchy of evidence that favours positivism leads to an evidential simplicity which excludes a wider collective body of knowledge and cannot address complex human needs, such as those which are manifest in mental distress.

As such, the idea that we now gather here with respect to methodologies for global mental health is the recognition of the deleterious, or indeed injurious, effect that the (nominally Western, psychiatric) epistemic standpoints of mental health interventions may confer upon both individuals and communities. Epistemic injustices, as we consider them here, are not only those injustices that may arise because of (knowable) economic, social or cultural inequalities, for instance poverty or systematic discrimination on the grounds of gender or race (see Lakeman 2010). Rather, epistemic injustice is understood to galvanize and sustain such injustices through its denial of the means and capacity through which individuals and communities may be deemed 'legitimate knowers' (Liegghio 2013:123) rendering their capacity to know as being less legitimate, or 'something other than knowledge' (Liegghio 2013:124). This has pressing consequences for mental health intervention and the methodologies it uses to advance and replicate its mission, which we now discuss.

We argue that different paradigms of research will be necessary in order to deliver locally meaningful health interventions in LMICs. These methodologies are likely to challenge the bio-medical structure of EBP and consumer-provider power dynamics when applied to

communities with their own concepts of mental illness, such as the possibility of spirit ‘possession’, and specific socio-political relationships with health care, such as what ‘health’ means to people who need to work. A wide range of methodological approaches are at the disposal of researchers and policy makers to determine what mental health practice is ‘culturally appropriate’ to LMICs. Our aim here is not to describe specific methodological interventions, but outline a number of philosophical concerns regarding methodologies for future practice. Specifically, we address the concern for representation/exclusion in the guise of epistemic injury, presumptive methodologies arising from a predilection for Western notions of selfhood, and ethical issues.

Goal 1: Address epistemic injustices

There is emerging a tension between the promoting of narrative approaches to medicine/healthcare that claim to represent authoritatively service user interests, and the colonisation of these approaches by medicine and its allied professions. The methodological challenge is not only locating what is 'best practice', but also one of epistemology (the nature and status of knowledge) and ameliorating the risk of epistemic injustice (Fricker 2003, 2010). Therefore, one methodological aim is to ameliorate the effect of epistemic injustices on the truth claims of ‘others’.

One form of epistemic injustice, testimonial injustice, arises from prejudice (Fricker 2003, 2010). For the researcher, this might result in those being researched being denied credibility. Two antecedent conditions are at play in such circumstances: disbelief, whereby what is being heard is interpreted as incredulous; and attenuation, where what is being heard is moderated or weakened. For instance, someone experiencing the psychological consequences

of childhood abuse may be deemed an unreliable witness; her or his recollection of an experience enfeebled due to its historical nature.

Another form of epistemic injustice, hermeneutic injustice, is an *a priori* condition for testimonial injustice where the threshold for testimonial injustice is not reached because the speaker lacks the ‘conceptual or linguistic resources’ (Coady 2010: 110, Hookway 2010) that render credible their utterance. For instance, the person reporting childhood abuse may not possess particular forms of symbolic capital (for example, linguistic resources or knowledge of the law) to sustain a credible account of their experiences, particularly in the presence of expertise or authoritative others.

Fricker (2010) does discuss some strategies for the regulation of testimonial injustice, for instance, the use of ‘structural mechanisms’, including ‘anonymization’ (Fricker 2010: 165), the raising of correspondents’ ‘self-awareness’, and institutional training and sanctions to silence prejudicial attitudes. However, the first of these may be problematic in the context of global mental health: the concept of anonymity is rooted within the ideologies of Western biomedicine and hence may not be readily exported to non-Western contexts. Furthermore, whilst psychological techniques such as practitioner ‘self-awareness’ might be useful tools for the amelioration of epistemic injustice, the practitioner would also need to be cautious that the extinguishing of prejudice did not deaden the need to differentiate and prioritise.

The notion of hermeneutic injustice is more profound. In exporting knowledge and practice to non-Western contexts, practitioners will need to be critically aware of the forms of capital, personhood and governance on which that practice functions in Western contexts. Exporting Western mental health expertise without the ameliorating factors risks exporting, unprotected,

its flaws and inadequacies. Practitioners therefore need to be equipped with a critical understanding of what does *not* work in the West, (for instance, drug-induced movement disorders which stigmatise schizophrenic patients) in order to avoid replicating its symbolic and structural disadvantages to others.

Goal 2: Problematize the Western self

It may be argued that, in the Western neoliberal mental healthcare context, individuals are increasingly incited to 'work on their selves' (see Rose 1998, 1999, *passim*); that is, individuals are not only unitary subjects of/for psychiatric medicine, but are increasingly obliged to become responsible for their own psychological well-being. Although enforced treatment of *some* psychiatric subjects remains legally sanctioned in HICs, interventions are increasingly self-administered, either as expert-prescribed therapies or as psychological interventions *consumed* outside the traditional medical context (psychological 'self-tests' in lifestyle magazines, media, and so on). Psychological technologies such as CBT (cognitive behavioural therapy) and 'Mindfulness' (which here we understand as a Westernized version of Buddhist practice: see Keng *et al* 2011) for cultivating 'self-help' and resilience have arisen and become desirable in particular contexts. This is not only because they are evidence-based 'best practice', or cheaper, but also because they interrogate and corroborate the preferred way people are increasingly obliged to live, work and consume in the neoliberal democracies of the Global North.

Concepts such as 'resilience' and self-awareness are arguably products of the same discourses that produce the recognisable Western subject. This individuated notion of the subject may be highly problematic, and disruptive, when translated to a context where different forms of subjectivity and community identity are afforded greater privilege. As such, we argue that not

only should (Western) healthcare practitioners be encouraged to reflect upon their own cultural and intra-disciplinary predispositions and how these – perhaps instinctively and without deliberate oversight – serve to ‘make up’ the subjects of healthcare practice (Cox 2009), but they should also endeavour to develop critical methodologies and 'ways of knowing' people unframed by a Western conception of the individual subject.

Goal 3: Address ethical issues for global mental health service development

The globalisation of mental health knowledge and practice cannot be presumed to effect a paralleling of Western ethical principles in non-Western contexts. Equally, however, it does not suggest a nihilistic retreat into ethical relativism or defilement of human rights. Although the notion of ‘human rights’ suggests universalism, the privileged concepts of Western biomedicine – autonomy, beneficence, non-maleficence, social justice – (Beauchamp and Childress 1994) may require local epistemic interpretation:

“This does not necessarily mean that ‘human rights’ or ‘democracy’ are not important concepts ... It just means we have to question our understandings of these ideas in light of ‘actually existing’ realities, histories and epistemologies, with the explicit aim of decolonialising our own understandings of what we are observing” (Goldstein 2012: 305-6).

In biomedicine, the issue of the transferability of Western ethical principles to non-Western context is subject to on-going debate. Wahlberg *et al.* (2013) identify three dimensions of critique: those which question the applicability of Western ethical practices to locations deemed ‘resource poor’; those that suggest that bioethical principles reflect post-war, Westernized accords on human rights; and those that, drawing upon ethnographic enquiry,

have foregrounded the vitality of ‘ethical variability’ (Wahlberg *et al.* 2013:3) in specific contexts.

For mental health, these issues are apposite. Western ethical governance techniques and processes can be seen to be a function of normative values, expert knowledge, and specific legal and institutional contexts. For instance, in the UK, ethical issues pertaining to ‘capacity to consent’ are legally framed: who is deemed to ‘lack capacity’ reflects societal norms and is reliant upon ‘expert’ knowledge, a supportive bureaucratic structure, a functioning legal system, and knowledge of the population. In other contexts, some or all of these may be differently performed, if at all.

Conclusion

We argue that the sea-change in HICs toward user enfranchisement and recovery principles provides an example of the tension between medical and social models of mental health provision. These tensions are likely to be exported to LMICs which are less equipped to engage in debate or provide an opposition to the power of the medical establishment. The World Health Organization aims to export community-based practices; however, in vulnerable communities, epistemic injustices may be realised in the absence (or recognition) of ‘grassroots’ representation. Unless the WHO also exports the *critiques* of medical conventions, especially through its own symbols – such as evidence based practice – it risks imposing ecologies of mental health research and practice quite at odds with culturally diverse communities.

Campbell and Burgess (2012) suggest that it may be politically astute to continue to ‘wear the clothes’ of the disease model medicine in order to engage governments in delivering support

for mental illness. However medical power may prove resilient: Freshwater and Rolfe (2004), Lambert (2006) and Prilleltensky (2003) all suggest that medical dominance will persist because health institutions, governments, private health providers and third party payers will not relinquish institutional power. Mykhalovskiy and Weir (2004) see evidence based practice providing a new arena for social sciences within medicine; not sidelined by medicine and medical/biological methodologies. Social sciences have the capacity to illuminate ‘discursive preconditions’ of evidence based practice (Mykhalovskiy and Weir 2004:1060), are able to recognise the community and cultural context of the ‘patient’ or ‘service user’, and can provide methodologies with which to critique bio-medical evidence and offer manifold perspectives (Marks 2002).

In summary, we propose that in aiming to translate Western mental health expertise to LMICs, those charged with delivering service improvement need to base their interventions on evidence derived from the context in which it is delivered. Existing evidence of effectiveness of service provision in HICs is based on Western contexts, populations and historical dialogue which will not apply to many community contexts in LMICs. Whilst the over-arching methodological practices may be similar to those deployed in the Global North (for instance, the use of RCTs, or the deployment of qualitative methods such as interviewing of focus-group designs), practitioners will need to ensure that the epistemic and ethical standpoints of the West, along with their commensurate notion of the ‘self’, are not naïvely implanted into methodologies as they are ‘exported’ into the Global South.

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