THE MARIWALA HEALTH INITIATIVE JOURNAL

RE

Mental Health and Climate Justice

FRAME

Open Call for Submissions 2022

About MHI + ReFrame

Mariwala Health Initiative is a capacity building, advocacy and grant-making agency that focuses on making rights based mental health accessible to marginalized persons and communities in India.
We also work toward changing conversations and discourse around mental health (MH), by foregrounding voices that are marginalised by structural oppression and dominant narratives.

One of the ways we do this is by publishing a yearly journal called ReFrame -a journal to challenge existing norms and explore diverse voices within the mental health space — expanding horizons for who gets to participate in such conversations in an effort to firmly ground mental health in a contextual, intersectional, rights-based, intersectoral framework. It is envisioned as a tool for mental health practitioners, advocates, activists, scholars, students, experts, funders, government officials, non-profit organizations — and those from closely allied sectors. ReFrame's central impetus is to foreground lived experiences and knowledge from the margins in transforming our MH system.

THE MARIWALA HEALTH INITIATIVE JOURNAL IS A TOOL FOR

Mental Health Practitioners / Advocates / Activists / Scholars / Students / Experts / Funders / Government Officials / Non-profit organizations / Closely Allied Sectors

REFRAME 1 (2018)
REFRAME 2 (2019)
REFRAME 3 (2020)

Open Call for Submissions 2022

Mental Health and Climate Justice

PREVIOUS THEMES

Funding Mental Health

Bridging the Care Gap

Mental Health beyond Clinical Contexts

Unpacking Structural Determinants of Mental Health

Theme 2022

Climate change is a social determinant of mental health. There is rising literature on the increased rates of depression due to air pollution, suicidal ideation and post traumatic stress disorder due to floods, landslides and other such climate disasters. In addition, we must consider the unique vulnerability of people with physical and psychosocial disabilities to climate change and its accompanying systemic failures. This calls for mental health advocacy, care systems, policy and interventions to address and ally with resistance against climate change.

"Part of the problem is that climate change research tends to focus on economic sectors – water, infrastructure, agriculture, settlements and so on – rather than human groups. Often, climate change is thought of sectorally, in terms of agriculture, water and so on, rather than in terms of a people, group or livelihood.[1]" - **Rachel Baird**

It's critical to acknowledge that mental health and climate change discourse are intertwined by matters of justice, social well-being, rights, safety and community rehabilitation. Access to mental healthcare and safe climatic conditions are both regulated by law, policy, market forces and other systems of politics.

Given this, we must ask:

- What is the need for mental health and climate change to permeate each other's isolated discourses?
- Who are the stakeholders represented in this intersectional discourse?
- How do such discussions interact with policy, legal change, community care networks and mental health services?
- What is the paradigmatic change needed in conversations of climate change, mental health and their intersection?
- What are the systems mediating between climate hazards and their mental health implications?
- What are the required considerations and target outcomes to keep in mind, while designing preventive policy and rehabilitative services and programmes for climate related distress?

This issue of Reframe aims to explore all such inquiries and more.

[1] Baird, Rachel. "The impact of climate change on minorities and indigenous peoples." *Briefing). Minority Rights Group International: London* (2008).

Climate change and mental health: situating the macro structures

1. Systemic responsibility is being shifted onto the individual

The intersections between discourses of mental health and climate change emphasise one unfortunate commonality between both – the individualisation of responsibility for systemic faults. Neoliberal norms pathologise mental health reducing it to individual traits, personality, biochemistry and 'behaviour' and similarly, also individualise the approach to climate movements.

From emphasising individual carbon foot-print reduction to fixating on the replacement of plastic straws, a mainstream understanding of climate advocacy assumes change in an individual's behaviour by surveilling microscopic lifestyle choices.
This neglects, (often deliberately) the large scale effects of industrial economies, electronic waste dumping, deforestation for elite settlements, and the disproportionate impact of western neoliberalism and imperialism on the environment.

Not only are individualised narratives of climate protection, disability and mental health farcical and ineffective, they are also extremely oppressive, classist, casteist and ableist. The ability to choose alternate straws/no straws, taking downtime versus working, bicycles over cars, eating healthy or organic, and other 'lifestyle changes' remain within the arena of a privileged few.

So, how can imaginations of sustainability resist individualised pretence? How can educational community interventions resist the systems that are causing eco-destruction and eco-ableism? How can climate advocacy recognise the disproportionate risk faced by persons with disabilities, indigenous communities and centre their needs?

2. The distribution of harm is unequal

Rising hot waves increasingly predict psychological distress. Night-time heat is associated with poorer sleep

leading to deteriorating consequences on mental health. Hot days have shown links with self harm. Rising temperatures have predicted farmer's suicide. There are documented effects of occupational heat stress faced by workers. And, literature reports, eco-anxiety, and solastalgia (distress caused by the changes in or destruction of home or land to climate change such as deforestation, floods etc), especially among young people, describe fear of environmental destruction and climate disasters respectively.

Importantly, such implications have a disproportionate impact on South Asian countries, lower and middle income countries (LMIC), people with physical as well as psychosocial disabilities, indigenous communities, agrarian societies and primary sectors (fishing, forestry, mining etc). The distribution of harm therefore, is not random or coincidental but evidence of unequal access and safety nets.

Even as we recognise the environment and climate as a social determinant of mental health, we must acknowledge that disability and environment are undervalued by the same systems - those of neoliberal development, capitalism, colonisation, rapid industrialisation. For example, a for-profit industry is likely to invisiblise both, persons with disability as well as environmental effects; in some scenarios, disabilities can be caused by pollutants in air or water; and, persons with disabilities are more at risk during a climate emergency, a fact that is compounded by the reality that they are not considered in disaster planning nor in relief efforts when it comes to environmental disasters.

Thus, for this issue of ReFrame, we hope to engage with some of the concepts below to build allyship and shared action between mental health and climate justice movements:

- What are the interlinkages between above mentioned phenomena, climate change and mental health?
- How do identities of caste, nationality, ethnicity, religion, gender, ability, occupation, class mediate between 'risk factors' such as drought proneness, overgrazing, floods,

earthquakes and the intensity of their implications?
- How are the consequences of both climate change and consequent mental distress distributed unequally?

Contrast this with the individual responsibility approach to both environmental sustainability and mental health even as some communities and individuals bear a disproportionate brunt of both. In fact, poverty, disability and climate change seem to be enmeshed as well as cyclically reinforcing each other. Who and what then, benefits from this individualised narrative?

Climate change and mental health: foregrounding the voices from the margins

1. The role of climate related migration
Climate disasters and climate induced migration create multiple risks to mental health. These include, but are not limited to lack of livelihood rehabilitation, food and housing insecurity, lack of citizenship recognition, refugee and migrant oppression, and increased poverty and violence.

The WHO claims the displacement of 20 million people every year due to hazardous climate conditions (heavy rainfalls, cyclones, earthquakes) that push them to the margins of "statelessness." Caught in exhaustive rides across insecure borders, people suffer physical and mental adversity, facing cultural and linguistic alienation, incarceration, harassment surrounding citizenship issues and hostile climate conditions. For example, from the Bangladeshi population that survived the 2019 flood, 57.5% experinced suicidal ideation and 2.0% attempted suicide.

Another example: Rising air pollution exposes the 15 most polluted LMIC to increased rates of depression.
In times of ethno-nationalism, how do concerns of mental health interact with climate refugees,
loss of nationhood, and homelessness?
- In times of rising flood proneness of inhabited coasts, how do notions of "legal citizens" and "illegal citizens" oppress migrants?
- In times of extreme inter-state political hostility especially in South Asia, where do the climate displaced families of Bangladesh, Maldives and

Sri Lanka situate themselves in both climate and mental health advocacy?
- How does mental health law, sustainability policy and rehabilitation services engage with anxieties and insecurities of lost livelihood?

The increasing risk of migration even within a country's borders disproportionately exposes persons with disabilities to migration violence, mobility trauma, homelessness, livelihood insecurity and inaccessible care.

2. The need to incorporate a rights/ social justice lens

These examples illuminate why rights and social justice must be a central lens to mental health and climate change - by acknowledging climate politics, the existence of power imbalance and contexts of oppression, both in terms of vulnerability to as well as lack of access to recourse in both climate justice and mental health. The communities most impacted are ones most marginalised in narratives, research, services, policy and strategising goals towards solutions.

For instance, there is much focus on youth mental health when it comes to climate change. This is not only a simplistic view of 'youth' but also ignores many other communities who are deeply affected. Adivasi communities and movements have upheld *Jal, Jangal, Zameen* for decades and are at the margins of both climate and mental health discourse. (This mirrors the experiences of indigenous communities worldwide who have deep relationships with environment and climate and yet, disproportionately face oppression in climate justice and mental health). In addition, farming or fishing communities - both critical for food security - shoulder an unequal burden of climate emergencies and yet remain sidelined in both climate justice and mental health.

The above also clearly shows the linkages between equity, justice and sustainability and points to the necessity of climate justice as part of mental health work. (Climate change asymmetrically affects access to livelihood, housing, sanitation, water which especially in LMIC can trap people

in a vicious circle of homelessness, poverty, mental illness.)

Thus, it is imperative to climate and mental health advocacy, policy and care to uphold the knowledge of communities marginalised by climate emergencies.

- How can climate-related mental health engage with difficult conversations of deliberate power equations rather than viewing both mental health and climate consequences as natural givens?
- How can development projects uphold indigenous knowledge and rights?
- How does human trafficking and climate change dovetail and what may it tell us about trauma-informed mental health?
- How can international law councils recognise disproportionate risks and implications of neoliberal climate exploitation that LMIC and South Asia bear?
- What does it mean to make climate protection affirmative to rights of persons with disabilities, women, oppressed caste and adivasi communities?

The role of mental health in Climate Justice

Keeping this macro lens of climate and mental health politics in mind changes the landscape of responses we draft to climate induced trauma. This requires both preventive policy and advocacy and a macroscopic lens to disaster planning and post-disaster empowerment.

We need to explore the role the above contextualisation of mental health plays in the backdrop of climatic uncertainty, in conversations of clinical services and rehabilitation? How do we inform the conversations around PTSD, Depression, Anxieties and Psychotic expressions and situate their appraisals in discourses of climate trauma, migration and refugee crisis? Is there a need to shift paradigms of the migration related rehabilitation services and policies?

Advocacy and Policy

- How do we envision mental health care in policy and services for climate induced distress?
- How can conversations of therapeutic care go beyond clinician rooms to policies of rehabilitation, citizenship, livelihood security, public healthcare and housing?
- How can mental health policies secure self-determination and right to one's homeland and control over its resources?
- Building evidence and voices of above mentioned communities in the designing and implementation of advocacy, policy and all systems of care for justice to prevail in both climate and mental health advocacy.

Affirmative Services and programmes

- In both community care and clinical intervention, how can we incorporate a rights based lens and equip practitioners to respond to structural climate trauma?
- How does climate change inform the concepts of vulnerability and resilience?
- How can we equip practitioners to participate and create a network of tangible avenues towards employment, housing and food security for uprooted communities?
- How can we re-design rehabilitative systems of community support for those impacted by catastrophes, from “expert interventions” to reliance on peer-groups, comradeship, and community safety nets.

A Typical Article

RESEARCH

Interrogating the Cut + Paste of 'Recovery'

Experts by experience build locally valid definitions

BY Sumeet Jain, Kaaren Mathias, Clément Bayetti, & Sushrut Jadhav

contexts for recovery

This article challenges received wisdom on existing concepts of 'recovery' from mental suffering and demands that people's voices ought to be central to future policy, clinical care, and applied research.

'Recovery' is a concept that proposes we can live fulfilling lives despite our suffering. It has been embraced by people affected by mental distress in high-income countries (HICs). Indeed, current ideas of recovery have emerged from the particular histories of mental health service user movements in HICs[1]. This represents a significant shift in the idea of recovery, from being about symptom remission to suggesting a process – a "journey of change" – for the individual[2].

In the Indian context, whilst it has been the subject of much discussion in the mental health field, there has been limited focus on recovery in formal mental health services[3]. The idea of recovery has been welcomed, although the frameworks for addressing this have been adopted rather uncritically from high-income settings. There are still almost no social recovery tools developed for Indian contexts, or together with affected persons. Data on what recovery means to Persons with Psychosocial Disabilities (PPSD), carers, and local communities, is crucial to ensuring that India's community mental health programmes embed locally valid understandings. How social recovery takes place, what aspects are central (having friends, or paid work, or being able to have fun), the measures of social recovery, and the types of support that people with mental health problems would like; all vary in different contexts.

defining "recovery"

In the early 2010s, we noted the emergence of the term "recovery" in Indian psychiatric circles and in India's new mental health policy. This led us to ask two questions:

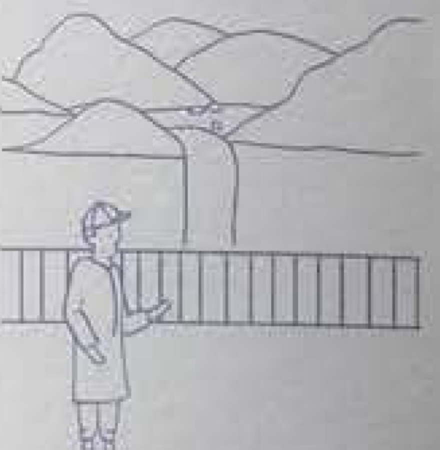
1. What is the distinctive history of this concept?

2. How relevant is it to the Indian context?

In parallel, Mathias, in setting up a community mental health programme called Burans in Uttarakhand[4], faced challenges in operationalizing conventional western recovery tools. These tools were often inaccessible to people due to the way they were structured, and the lack of cultural validity[5]. Both the underpinning ideas of recovery, and the domains embedded in these tools, seemed to hold little meaning or relevance to the lives of the PPSD with whom the Burans team was working.

These challenges resulted in a one-year pilot project[6] to develop a pictorial recovery tool relevant to the north Indian context[7]. A core idea underpinning this work was the importance of identifying "Indian vernacular concepts of 'recovery', their cognate and embodied equivalents.[8]" Our effort was to operationalize this in the context of a short project cycle. We began by holding workshops, and meetings with PPSD and carers – all of whom were "*experts by experience*". We used participatory methods, including storytelling, discussing photographs,

A Typical Article



Images from Swasthya Labh Saadhan

drawing pictures, and focus group discussions to better understand local meanings of recovery, and generate valid domains for the tool. Two key Hindi language terms on which the group agreed were *swasth rehna* (remaining in good health) and *theek hona* (to get well). The group named a resulting tool *Swasthya Labh Saadhan* (recovery tool for health). The aspects of recovery that emerged emphasized the importance of a person's role as an active member of the community and family, being spiritually engaged, and contributing to the family – perspectives that are missing in most western recovery tools.

A local artist created pictures representing domains of recovery, an important adaptation for settings where literacy may be a limiting factor. The use of this co-developed mental health recovery tool among a pilot group of 26 people with severe mental illness led to improved mental health, and generated local conversations around recovery between lay workers and PPSD[9].

translating to practice, policies and communities

Several questions that emerged from this work have relevance for India's community mental health services:

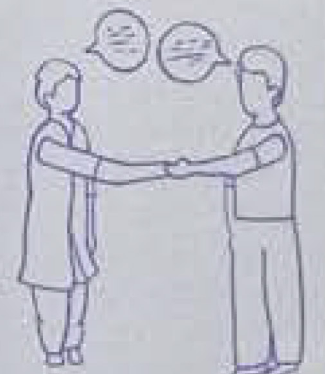
what does "recovery" mean in indian contexts?

If we are to develop services that are locally valid, it is crucial to embed a participatory process of identifying domains of recovery in each context. Conceptions of what recovery means may widely vary between policy makers, clinicians, PPSD and carers. These differences are yet to be understood in this context, but are crucial for culturally valid visions of recovery to emerge. Independent of services, more research, including analysis of existing qualitative and ethnographic data, is needed to understand trajectories of recovery as well as the intersections of psychosocial disabilities with other forms of marginality (such as gender, religion and caste). This is crucial, given India's cultural and social diversity.

how can services better embed co-production with "experts by experience"?

The depth of our approaches was limited by project time. A recent paper by service user/survivor researchers highlights the unequal power relationships that accompany co-production in mental health care[10]. In our research, we soon became aware of these power differentials

> *The important concern is how diverse voices can truly inform the priorities and directions of mental health care systems.*



between researchers/mental health workers, and people with psychosocial disabilities and carers[11]. A first step towards mitigating these inequalities would be to ensure that the voices of "experts by experience" are heard and dedicated in planning, developing and delivering community mental health care in the country. This would, however, be only a start – the more important concern is with how diverse voices can truly inform the priorities and directions of mental health care systems? People-centred approaches to health systems offer a useful framework[12]. These approaches recognize the centrality of individual, family and community perspectives, conceptualize them as participants and beneficiaries in the health system, and advocate for organizing health services around people's needs.

how do we develop supportive community environments?

A central limitation in our research was that we primarily addressed individual narratives and domains of recovery. While important, this can serve to obscure the structural issues that shape well-being and marginalization — which may be beyond individual control and that limit service user involvement[13]. For example, we know very little about how social inequalities such as caste, identity intersect with mental health[14]. In thinking about recovery, research and practice must be informed by an understanding of the wider social and material forces that shape suffering, including gender, age, social class, and caste[15]. ◘

Dr. Sumeet Jain is Senior Lecturer in Social Work at The University of Edinburgh. Current research in South Asia examines mental health 'innovations'; local approaches to 'recovery'; the role of community health workers in delivery of mental health care; and mental health, marginality and social exclusion.

Dr. Kaaren Mathias is the Mental Health Programme Manager, Emmanuel Hospital Association (www.eha-health.org) and Project Director of Burans in Uttarakhand (https://projectburans.wixsite.com/burans). Research interests include models for community mental health, youth resilience, participation, exclusion and inclusion of people with mental distress, gender, equity, and health system strengthening

Clément Bayetti is a Doctoral Student at University College London (UCL), UK and an Adjunct Faculty at Washington University, St. Louis, USA. His research explores the process through which psychiatry students in India acquire professional identity and how this shapes clinical encounters and outcomes.

Dr. Sushrut Jadhav is a street psychiatrist working for homeless people. He is a clinician anthropologist and Clinical Associate Professor, Cross-cultural Psychiatry, University College London. Dr Jadhav is currently engaged in field testing cultural psychological therapy for caste mediated distress.

Format

- Do submit single articles with a limit of 800 – 1200 words.
- Along with those, do submit a Headline (15 words) and sub-headline (25 words).
- We would also like the author's biography (40 - 60 words).
- Please submit this in Calibri, 12 point font.
- We require citations in MLA (Modern Language Association) style, at the end of the article - footnotes.
- In case you have contributed in an individual capacity to ReFrame before, we ask you wait two years before submitting an individual piece again.

Content

- The article must be relevant to India and/or a South Asian context.
- In case there are visual cues/ drawings/ diagrams/ representations that link to your piece — please do share those as it will help our lovely design team.

Tonality

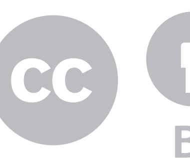
We do intend that ReFrame be a valid form of communication and knowledge production and thus prefer a tonality of content that is accessible, informative, insightful, inclusive, explanatory and rigorous.

Process

- An editorial board of 5 persons will review each submission.
- Each submission may be edited for clarity, inclusion and rights based ethics. For any notable problems of meaning, content or style - we will correspond with the author of the piece to discuss editing suggestions.
- For other routine edits such as misspellings, tense confusions, sentence structure or adding headings for paragraph breaks, we may not be able to confirm correspondence.

License

All published pieces will fall under a creative commons copyright - free to use/share with citation.



Submissions

Mail submissions and queries to
contact@mariwalahealthinitiative.org

The deadline to email your submission
is 15th June, 2022.

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