THE MARIWALA HEALTH INITIATIVE JOURNAL

RE

Global Mental Health From the Margins

FRAME

Open Call for Submissions 2023

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 marginalised 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 trandforming 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)
REFRAME 4 (2021)
REFRAME 5 (2022)

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initiative

Open Call for Submissions 2023

Global Mental Health from the Margins

PREVIOUS THEMES

Funding Mental Health

Bridging the Care Gap

Mental Health beyond Clinical Contexts

Unpacking Structural Determinants of Mental Health

Mental Health and Climate Justice

Theme 2023

Our broad aim with this year's ReFrame is to critically examine dominant narratives and advances within the global mental health field, and view them through the lenses of marginalisation, disability justice and indigenous experiences, among others. Part of this is acknowledging historical legacies - psychiatric, colonial and racial and exploring how they are deployed in global mental health today. These lenses can be used to engage with a variety of constructs such as youth mental health or the idea of common measurement systems.This issue will be examining the field of Global Mental Health, from the margins specifically - rather than solely exploring mental health from the margins.

Global Mental Health (GMH) is an emerging domain of research and practice that promotes equitable mental health and well-being for all. Specifically, “GMH is committed to preventing and treating mental, neurological, and substance use conditions especially for vulnerable populations such as poverty, conflict, and trauma and in low- and middle-income countries (LMICs).” (APA)[1]

Background: Global Mental Health

Initial developments in the field of Global Mental Health (GMH) can be traced back to a series of papers published in 2007 by the Lancet authored by academics and researchers affiliated with bodies such as the World Health Organisation (WHO), the World Bank as well as universities largely based in the Global North. This series called on a range of global actors including international donors and research agencies to scale up services to address mental disorders with a specific emphasis on low-income and middle-income countries.

The Lancet Commission on Global Mental Health and Sustainable Development (published in 2018)[2] traced the trajectory of this field and highlighted the role that global mental health played in having Sustainable Development Goals with mental health indicators.
A virtual global alliance called Movement for Global Mental Health (MGMH) was formed in 2008, followed by the Global Mental Health Peer Network (GMHPN) in 2018. In this series of papers, the majority of Commission members were experts or academics affiliated to Global North institutions and one user-survivor voice.

[1] O’Donnell , K., Eaton , J. and Lewis O’Donnell, M. (2019) Global mental health – What’s up? Recent developments and directions in the field., *American Psychological Association. Available at: https://www.apa.org/international/global-insights/developments-and-directions* (Accessed: 11 October 2023).

[2] Patel, Vikram, et al. “The Lancet Commission on global mental health and sustainable development.”
The Lancet, vol. 392, 27 Oct. 2018.

The commission reported that attention was paid to the treatment gap in LMICs with implementation research initiatives and a doubling of development assistance for mental health after 2007. A set of indicators to monitor mental health in the SDG-era was also proposed.
The key recommendations of the commission included “scaling up services for mental disorders, action on social determinants of mental health, embracing digital technology, the need for public policies and the need to address threats to global mental health.”

These threats ranged from the limited impact of pharmacological and clinical treatments at population levels to an increase in adverse social determinants. Interestingly, among the identified threats was the critique of the dominant biomedical narrative and of a promotion of the Western psychiatric framework. Another noted threat was the fragmentation of advocacy due to “diverse constituencies and scientific perspectives” - such as clinicians focusing on expert-led treatment for mental disorders, civil society activists foregrounding discrimination or neuroscientists propounding brain mapping.

Taking stock in 2023:
Post the 2018 Commission, the COVID pandemic and a focus on climate change have meant that increasing attention has been paid to mental health, public health, global health, and planetary health. How has global mental health adapted to this changing world? What are the ways global mental health has informed the principles and goals of sustainable development? How has global mental health adapted to recent global upheavals - viral infections, war, a growing global food crisis fuelled by rising prices of food, fuel, and fertiliser i.e. a significant increase in adverse social determinants? What are the ways in which outlined opportunities such as digital technology have operated?

It is clear that from the inception of the field in 2007 until the present day in 2023, the same voices tend to be highlighted over and over in the field of Global Mental Health. These expert

and/or academic voices continue to be affiliated with elite American and British universities or organisations. Finally, papers on GMH are likely to be published in psychology, public health, and psychiatry journals such as Frontiers in Psychology, Lancet Public Health and Jama Psychiatry. The 5 most cited journals for the fields of psychiatry, psychology and public health are all based in the USA, UK and Switzerland. Similarly so with bodies such as the World Health Organisation (WHO) or international funding and research bodies - who also continue to reflect the largely Eurocentric biomedical tradition. What systems and actions continue to uphold this hegemony? And what are the ways in which we can reinforce the threats as outlined in the 2018 Lancet Commission so that we may move towards standards of mental health informed by paradigms of healing justice and social justice?

Putting the 'Global' in Global Mental Health:

Addressing the discourse in global mental health is important if it is to be truly global, rather than a high-income country (HIC) led field. So, what are the ways in which we can foreground and action epistemic diversity in global mental health? If the aim is equitable mental health and wellbeing for all, what are all the ways in which mental health curricula should be grounded in human rights? Interestingly, many conversations in GMH seem to focus on the discourse of scale rather than the discourse of rights.

Since global mental health aims to address issues particularly faced in low and middle income-countries (LMIs), what are the implications of the dominant lens of seeing individual disorders and scaling up 'treatments'? Additionally, it is very important to ask whether access to health is the same as, or, interchangeable with health equity. Deeply connected to the above is the need to explore ways in which we should be challenging the medicalisation of human distress. This means critically examining the tools, questionnaires, scales and the very language(s) used in global mental health.

While we may speak of legacies of

violence from the psy-disciplines, from colonisation, racism, casteism, colonialism and centre those, we also need to articulate how we uphold structural inequalities in our own work in the Global South. How are these legacies upheld in discourse originating from the Global South?

It's important to state here that it is not a matter of Global South origin, but how people from the margins, who have shared experiences of oppression, can challenge dominant norms in global mental health.

For example, the idea of user-survivors, or the ways in which lived experience is commonly understood is markedly Eurocentric. How do western diagnostic criteria and institutions operate and define who can speak on the basis of lived experience?
While many in the Global South claim the term psychosocial disability - **many of us who use said term and are able to lay claim to discourse (and diagnoses) are likely to have savarna, cis-heterosexual, class and English speaking privilege.**

It is precisely these privileges that allow us space to speak, to attend international mental health research conferences or global youth mental health in the USA or Schengen geographies. Thus, in what ways must we build awareness of our collusion with oppressive systems?

Discussing global mental health from the margins will necessitate focusing on how power works, where it is situated and how we can disrupt hegemonic power in mental health, be it systemic, geo-political, socio-economic and/or based in structural inequalities.
For example, the fault lines of stigma are drawn in very neat, academic Eurocentric diagnoses. How can stigma be structurally-informed?

These analyses of power and structural oppression and violence must also extend to research, data and the very production of knowledge, i.e., decolonising mental health. It is clear that such discussions must move beyond mere linguistics and find grounding in anti-oppressive praxes and transformative justice. This will require

concerted resistance to epistemic violence.

The term resilience is cropping up frequently - widely ranging across programs for adolescent school children or for communities affected by war. How do we understand resilience when it comes to oppression that is both historical, intergenerational and day-to-day? Is there any relationship between building resilience and building solidarity? What is the role of global mental health in movements such as Black Lives Matter, Trans Lives Matter and Dalit Lives Matter?

How can we reimagine frameworks to be intersectional and foreground liberation, social justice, psy-activism and acknowledge both the risks and resilience in resistance?

What are we looking for?

Foregrounding marginalised narratives in Global Mental Health can mean asking questions like:

- Who commissions research in this field? What does it look like? Who gets cited? Who gets researched and how? How much of academic publishing in GMH involves collaboration with local communities, survivors/ service users?
- How do we critique the agenda of treatment of mental, neurological, and substance use conditions in LMICs juxtaposed with the aim of equitable mental health for all?
- Where and how are recent digital solutions being put forth to address mental health concerns? Who is requesting, designing and championing the same? What specific mental health conditions do these solutions address, and how effectively do they do so? What age groups do these solutions target, and why?
- How has lived experience with mental health been defined? Does it fit LMIC contexts?
- How does a user-led or community-led movement such as neurodiversity both challenge dominant mental health paradigms yet reflect voices only from certain locations?

- What are the ways (if any), that global mental health engages with the carceral state? If not, how could such engagement inform the aim of ‘equitable mental health and well-being for all’?

- How can the margins inform trauma and trauma-informed approaches?

Sub-themes that can be Explored:

- Neurodiversity
- Suicide and Self-Harm
- Evolving Ideas on ‘Anxiety and Depression’
- Substance Dependency
- ‘Trauma-Informed’ Approaches to Mental Health
- Data and Common Measures of Mental Health
- Incarceration and Imprisonment
- Reproductive Justice
- Climate Change and Mental Health
- Artificial Intelligence and Mental Health
- Agency and Resistance

Perspectives needed include

(but are not limited to):

- Indigenous Knowledges
- Experiences of Migrant, Refugee and Displaced persons
- Feminist Movements, Transfeminism and Sex Worker Movements
- Labour Movements
- Mutual Aid
- Anti-Caste and Affirmative Action
- Anti-Race and Affirmative Action
- Feminist Understandings of Care and Justice
- Disability Justice Movements
- Critical Race Theory
- Housing Rights
- Neurodivergent/Mad Pride Movements
- Collective Care and Healing
- Communities Impacted by Conflict or Occupation

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:

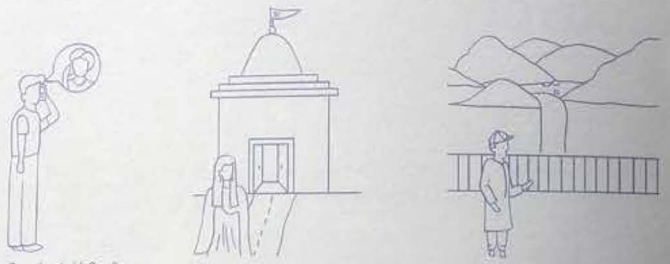
1. What is the distinctive history of this concept?

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 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.

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

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

- There are no content restrictions based on nationality or residence. Authors can hail from anywhere in the world, and focus on any subject matter as per the guidelines.
- 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.
- Authors from marginalised communities who are selected for the publishing will be given an honorarium.

License

Submissions

Mail submissions and queries to
contact@mariwalahealthinitiative.org

The deadline to email your submission is 10th December, 2023.

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