THE MARIWALA HEALTH INITIATIVE JOURNAL

RE

Mental Health beyond Clinical Contexts

FRAME

Open Call for Submissions 2020

About MHI

Mariwala Health Initiative is an agency that funds projects that focus 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.

Open Call for Submissions 2020

ReFrame

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. 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)

Mental Health beyond Clinical Contexts

PREVIOUS THEMES

Funding Mental Health

Bridging the Care Gap

Theme 2020

This year, ReFrame focuses on locating MH beyond clinical settings. Spaces, locations and geographies are part of mental health both metaphorically and literally. The history of psy disciplines and mental health is firmly rooted in asylums, hospitals and clinical institutions — which served to confine and ‘treat’ mental illness and distress. These spaces influence power relations between mental health professionals and users — marking one as the expert and the other as the subject.

But are these the only sites of mental health, of communicating distress or receiving care? As psy disciplines and mental health practice move towards deinstitutionalisation and social inclusion —what does it mean for those who live with psychosocial distress? Apart from spaces that are socially sanctioned and allocated for expressing and addressing mental health concerns, there is a focus on community, the usage of digital and online spaces, in sports and the arts as well as institutions such as schools, workplaces and prisons.

What are the changing landscapes of mental health? How have changes within economic, environmental, sociocultural, and political contexts shifted where and how professionals practice treatment or care? What are the sites of pathologisation beyond the clinical? What is a safe space to express distress? Especially as we contest whether asylums and clinics have been safe spaces - we need to ask the same questions of community mental health and beyond.

How and where is the community in mental health constructed, engaged and how does power operate there? Is community a space for mutual care? How do discrimination and experiences of oppression differ in the clinical versus the non-clinical space? How is mental illness or an expression of distress engaged with, in public and semi-public arenas? How does ableism operate in these different contexts?

How do we situate practices of mental health, care and support in non-clinical spaces? How much do medical understandings of distress influence spaces that are not the asylum or the clinic? In this vein, it would also be interesting to explore how mental health may be rooted in social, political and cultural contexts or, in current events. Which spaces approach mental illness as a familial, biomedical, individual, or collective responsibility? Look at contexts beyond the clinical as the construct of the asylum and/or patient is negotiated, challenged or rejected - and how this affects power relations, discrimination and oppression.

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

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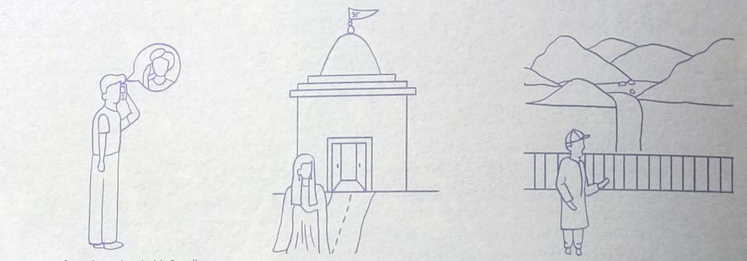


Images from Swasthya Labh Saadhan

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:

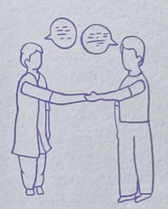
what does "recovery" mean in indian contexts?

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

- Single articles of 800 - 1200 words
- Headline of 15 words, Sub-headline of 25 words
- Author's biography of 40 - 60 words. Start off with your name and what you do. In the case of multiple authors add each bio of the same work count.
- Please submit this in a word document set in the font Calibri, at size 12 point
- We require citations in APA (American Psychological Association) style, at the end of the article - endnotes

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 3 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

Submissions

Mail submissions and queries to
contact@mariwalahealthinitiative.org

The deadline to email your submission is 30th April, 2020.

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