THE MARIWALA HEALTH INITIATIVE JOURNAL

RE

Unpacking Structural Determinants of Mental Health

FRAME

Open Call for Submissions 2021

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.

mariwala
health
initiative

Open Call for Submissions 2021

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. 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)

Unpacking Structural Determinants of Mental Health

PREVIOUS THEMES

Funding Mental Health

Bridging the Care Gap

Mental Health beyond Clinical Contexts

Theme 2021

What are the structural determinants of mental health? Approximately 970 million people around the world are living with mental health issues. Almost 75% of those affected live in low and middle income countries (LMIC). For high income countries, evidence and literature suggests that communities marginalised by race, ethnicity, gender and sexuality are disproportionately affected. Rather than country of residence, this indicates that disparities in mental health are a reflection of social inequalities and development inequalities. Further, institutional and public policies exacerbate these disparities.

The drivers of social inequalities and institutional inequality are the structures, systems and power relations that shape distribution of resources across communities and populations along lines of caste, gender, religion, class, sexuality, ability and their intersections. Called structural determinants they are historical, systemic and political forces that are the root causes of inequity in mental health. These determinants may exacerbate, mitigate or reduce the risk of poor mental health as well as exert influence over the opportunities for care and support available to people across their life.

According to WHO (2010) “Structural mechanisms are those that generate stratification and social class divisions in the society and that define individual socioeconomic position within hierarchies of power, prestige and access to resources. Structural mechanisms are rooted in the key institutions and processes of the socioeconomic and political context.” To illustrate, marginalised communities and individuals are disproportionately exposed to trauma and thus are at a greater risk for distress and mental illness. For example, discrimination has been linked to depression, anxiety and post-traumatic stress disorder. What are the structural or root causes of discrimination in different contexts?

How do structural determinants shape this experience and any potential for redressal or care? If we are to address mental health inequities, we need to address structural determinants.

The relationship between social and structural determinants

Taking social factors into consideration when it comes to inequities in mental health is not a new idea. The contexts and conditions in which people are born, live, work and age are called social determinants. Unfortunately, social determinants in mental health have been approached as individual behaviours and/or socioeconomic conditions. However, it is critical to go beyond social determinants such as food insecurity, education, income and housing to look at how these are shaped and distributed by structural determinants. To address inequality in mental health, we need to move from just correlating mental health with social determinants to exploring networks of causation between structural and social determinants in mental health.

While we know these structural determinants in our contexts lie on the axes of caste, gender, class, ability, sexuality - it is vital to examine not just the impact of these structures but also nuances of how these forces are deployed. Such work would be critical for us to challenge in multiple ways the inertia with which social factors have been treated in biomedical approaches. It is important to foreground that structural inequalities that affect mental health are driven by public policies and social norms. For example, the treatment gap is cited as a measure of inequality in mental health. On an average, 50% of those living with mental health concerns worldwide, and over 75%-95% of those living in LMIC cannot or do not access mental health care. How do structural determinants complicate the idea that greater numbers of mental health professionals are needed to tackle mental health inequities?

What are the ways in which structural and social determinants mutually reinforce each other, leading up to a cascading effect? How are the below factors shaped by structural determinants, what are the pathways in which they connect to produce mental health outcomes?

Public policies:

- Inaccessibility of education
- Poverty and deprivation
- Income inequality
- Food insecurity
- Livelihood issues
- Housing issues
- Climate Change
- Carceral systems: prisons, mental health institutions

Social determinants:

- Discrimination
- Social exclusion
- Adverse childhood experiences
- Exposure to violence, conflict
- Forced migration
- Natural Disasters

The role of mental health practitioners

Even as we assert the importance of these structural factors to mental health, it is critical to unpack and further explore how these determinants impact our contexts, clinical or community mental health practice.

With embedded biases in knowledge systems themselves, what are the ways and measures that need to be taken to dismantle structural determinants within mental health care?

Apart from a lack of culturally appropriate and structurally aware mental health services - professionals are trained to listen to only individual narratives, not place them within the context of structural determinants. How do we think about structural determinants as not only shaping the point of a clinical encounter but also understanding that distress is shaped by structural factors much before such encounters, as well as after?

It is important here to understand that the individual-structural is not a binary, nor are they in opposition to each other. So, we need to acknowledge that, since diagnoses are a method to access rights and care - clinical skills are as important as being able to see social and structural determinants and the interconnections between all three.

Keeping this in mind

How do we include these structural determinants in the conversation on effective, evidence-based or even quality care? How can we use the lens of structural determinants in our individual and clinical approaches? What ways should this lens be integrated, both when understanding client experiences and making recommendations for future action?

How do we join the dots between clinically defined ‘symptoms’ such as hearing voices, heightened reactivity to stimuli, depression, anxiety and their connection to social, political and economic inequalities such as food insecurity, homelessness or caste discrimination?

What are the methods we can use to centre that structural factors are likely to worsen experiences, care response, and life outcomes among those who live with existing mental illness? This specificity is critical to explore as user-survivors live in a violently ableist

world where norms and laws, policies and economic structures mutually reinforce exclusion.
Whether in individual clinical practice or community mental health, what are the ways in which we can equip practitioners to go beyond a tokenistic recommendation of ‘quality food’ or ‘shelter’ to skills of building and deploying referral networks and safety nets? Even as we equip practitioners, what guiding principles are important to remind us that the expert intervention should be situated alongside peer groups, networks and allying communities? And, keeping this in mind, how could we build multilevel, transdisciplinary interventions in community mental health, especially as many interventions focus on individual-level measures of mental health?

Lastly, we need to think about how structural factors inform not just future interventions but also advocacy.
For example COVID 19 made amply clear that food insecurity is a mental health issue, so how do we articulate and visibilise structural determinants around this issue as well as its mental health implications? It is necessary to explicitly address linkages between conversations around development, inequalities and mental health.

For example, the complex interactions of mental health with the sustainable development goals is important as it would inform not just conversations around development but also around inequality.

Some questions that would help us explore the above are:

- What is the impact of public policies on inequality and mental health?
- What would mental health awareness or anti-stigma campaigns look like if we incorporated a structural determinants lens?
- What would workplace mental health look like with such an approach?
- How can we evaluate socio-economic policies that can influence equitable public health?

Finally, it is important to speak from the positionality of LMIC contexts - even as we are subject to a monolithic Western based system - work around structural determinants can inform mental health inequalities in a multitude of contexts.

A Typical Article

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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:

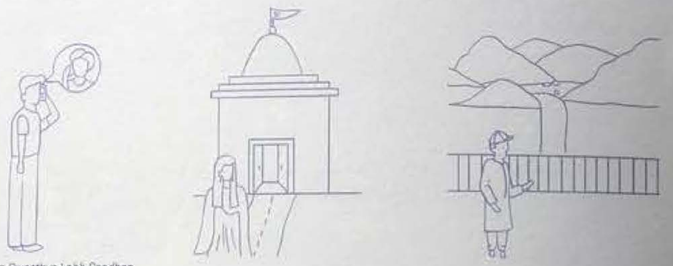
1. What is the distinctive history of this concept?

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

- 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 May, 2021.

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