Open Call for Submissions 2023

Global Mental Health
From the Margins

RE

FRAME

THE MARIWALA HEALTH INITIATIVE JOURNAL
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 transforming our MH system.
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 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
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.


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?
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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

- 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?
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
RESEARCH

Interrogating the Cut + Paste of ‘Recovery’

Experts by experience build locally valid definitions

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 services and user movements in HICs. 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.

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. The idea of recovery has been welcomed, although the frameworks for addressing this have not been adopted 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 people with Psychosocial Disabilities (PSDs), carers, and local communities, is critical 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 ‘Burance’ in Uttarakhand, 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. Both the underlying ideas of recovery, and the domains embedded in these tools, seemed to hold little meaning or relevance to the lives of the PRD with whom the Burance team was working.

These challenges resulted in a one-year pilot project to develop a local recovery tool relevant to the north Indian context. A core idea underlying this work was the importance of identifying ‘Indian vernacular concepts of recovery’, their cognates and embedded equivalents. Our effort was to operationalize this in the context of a short project cycle. We began by holding workshops, and meetings with PSDs and carers—all of whom were experts by experience. We used participatory methods, including storytelling, discussing photographs,
A Typical Article

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

Dr. Sarthak Jadhao is a 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. Kaziul Motfoe is the Mental Health Programme Manager. Embracing the framework of the programme's approaches, the centrality of community perspectives, conceptualize them as participants and beneficiaries in the health system, and advocate for organizing health services around priorities needs.

Clément Bayetti is a Doctoral Student at University College London (UCL), UK, and an Adjunct Faculty at Western University. Dr. Bayetti explores the process through which psychiatric patients in India acquire professional identity and how this shapes clinical encounters and outcomes.

Dr. Sunil Jadhao is a social psychologist working for homeless people. He is a clinical anthropologist and Critical Associate Professor, Cross-cultural Psychiatry, University College London. Dr. Jadhao is currently engaged in field testing cultural psychology therapy for clients 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.
• We would also like the author's biography (40 - 60 words).
• 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

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 10th December, 2023.