Global Mental Health from the Margins

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REFRAME

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UNITED KINGDOM
Throughout their history, the Roma have endured marginalisation and oppression as they encountered various societies. Often viewed with suspicion by non-Roma, they have suffered enslavement, abuse, and forced expulsion during their extensive migra- tion across Europe.
AUSTRALIA
While oscillate tween and rage with our therapists to of this burden, we cannot help but see this as an unveiling of the ongoing colonisation, hidden behind capitalist success and democratic 'civilisation', to reveal the ugly truth of our world. Indigenous Peoples have known this from the beginning. Colonisation and its various gaudy costumes – patriarchy, capitalism, racism, ableism, and environmental exploitation – continue to perpetuate systemic inequalities and injustices, deeply impacting the well-being of those living under its iron boot. Healthcare systems are only another piece of this puzzle. The biomedical mental health model, long dictating mental distress understanding and treatment, neglects colonial trauma's impact. Why are natural human responses to stressors like climate change, war, poverty, isolation, and oppression – such as anxiety, depression, and even psychosis – pathologised? Why are we labelled as disordered when we react to the disorder around us? Is it not natural to feel despair when our phone is full of images of innocents dying, of our lands burning and flooding, of pandemics forever altering our reality, and of the rise in hatred and disunity? If we consider what a healthy response to the crisis is, then perhaps we can see the decline in global mental health as a legitimate reaction to our environment. Humans are meant to grieve. We are built to live in connection with one another, and when disconnected, we are fundamentally not whole – we are unhealthy. Pathologising natural responses to near-constant existential threats does no one any good. Instead, what this does is direct attention to vulnerable communities who sit unwillingly at the hands of ongoing colonial power, leaving oppression unexamined. Our reactions are not symptoms of personal failings but responses to a society that continually fails us. We must transform to understand and radically address the root caus es
we be- despair meeting unload some
INDIA
Additionally, in India, the inequalities perpetuated by the caste system significantly affect mental well-being, as marginalised individuals face systemic discrimination and limited access to resources. However, global mental health efforts tend to prioritise issues that are more universally recognised, often overlooking the unique challenges of region-specific issues. This extends to marginalised individuals in prisons too, where too caste operates, and so their mental well-being suffers even more. The lack of acknowledgment of societal inequities and the non-inclusion of prisoners' well-being in global mental health discourse perpetuate the marginalisation of affected communities and undermine efforts to address mental health disparities on a global scale.This essay strives to explore prisoners' mental health as a global mental health concern. In addition, this piece will elaborate on a story of a from the lens of mental health within correctional institutions.I faced much discrimination in school, but my awareness back then was limited. On my first day chat with some classmates, I misunderstood 'convent' as 'government'. Thinking I government school ke bachhe [government school students]', I jumped up excitedly, but was stopped and corrected. Instead, these private school students discussed in angrezi basha [English] big cars, luxurious clothes and bags, and bahar gaon ka tour [outstation trips]. I felt invisible. For months I had no cour- age, hope, or desire to go to college. The sudden urges to cry my heart out; being unable to breathe sometimes; people telling me, till today, 'Tere paas toh quota hai [You've got quota]'; even my close ones acknowledging only the 'benefits' I got; questioning myself when people asked me to 'dress achhe se [nicely]' for events; the constant humiliations: I now know that these were not normal or okay and that I had real mental health concerns that were npt acknowledged by the people around me. Historically, mental health pro- fessionals have aligned with majoritarian power structures to per- petrate violence on the most vulnerable. The American Psychiatric Association and American Psychological Association in 2021 tendered public apologies for inculcating racism in psychiatry and psychology respectively. Dainus Pūras, the first psychiatrist to be appointed as UN Special Rapporteur on the Right to Health and Mental Health, in his several reports submitted to the UN General Assembly, lays emphasis on the need to shift towards rights-based mental health systems and away from the dominant biomedical model. The reports are critical of the mental healthcare infrastructure for using 'biased' evidence that favour biological interventions, contaminating the knowledge base in mental healthcare (such as phar-
prisoner caste-based of college, during a had finally met other

ReFrame, a journal by the Mariwala Health Initiative is a platform 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, and non-profit organizations — and those from closely allied sectors.

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mhi.org.in

/mariwalahealth
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022 6648 0500 //
contact@mariwalahealthinitiative.org

Grande Palladium, 8th floor, 175,
CST Road, Kalina, Santa Cruz (E),
Mumbai, Maharashtra 400098

Readers to note that this edition has an article discussing the ongoing Palestinian genocide. Additional content warning for: authoritarianism, colonisation, colonial extractivism, war, forced displacement, forced migration, dispossession, apartheid, civilian killings, torture, oppression, violence perpetrated by armed forces, life in conflict regions, cultural erasure, enslavement, serfdom, coercive sterilisation, communal conflict, casteism and caste violence, ableism, transphobia, queerphobia, conversion therapy, rape, molestation, sexual violence, extra-judicial murder, torture, human rights violations, human trafficking, racism, systemic discrimination, social exclusion, stigma, Roma Holocaust, incarceration, isolation, suicide, post-partum suicide, suicidal ideation, parasuicide (thoughts of self-harm), environmental exploitation, climate change, depression, stress, anxiety, PTSD, adjustment disorder, psychosis, trauma, historical and collective trauma, generational trauma, non-affirming therapeutic practices, physical abuse, verbal abuse, sexual abuse, polyvictimisation, misogyny, domestic violence, gender-based violence, abortion, miscarriages, reproductive violence, substance abuse, poverty, loss.

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EDITORIAL TEAM
Raj Mariwala
Ruby Hembrom
Manali Roy
Anugraha Hadke
Saniya Rizwan
Amalina Sengupta

COPY EDITOR
Janani Ganesan
Shraddha Mahilkar

DESIGN TEAM
Studio Ping Pong
studiopingpong.com

PRINT TEAM
SilverPoint Press Pvt. Ltd.
+91 9619737403

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PĀUS Page 28
Keisha Leon Page 32
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Rishabh Pinapotu
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Global Mental Health from the Margins

Contesting Global Mental Health
Raj, Amalina, Saniya
14

SERVICE DELIVERY · LAW & POLICY · HUMAN RIGHTS · PERSPECTIVE · RESEARCH · LIVED EXPERIENCE · ADVOCACY

Re-vision

Context

Engage

MHI's Work

Note from the Founder

In the last edition of ReFrame, I wrote about the need to break out of the 'business as usual' mode. The challenges facing humankind are increasingly complex, interconnected, and deep rooted. Temperatures continue to shatter records locally, regionally and globally. Conflict continues unchallenged in Gaza, Manipur, Congo and Sudan. The failure of international government bodies, courts of justice and civil society as the world watches attacks on hospitals, aid workers, schools, watches ethnic cleansing whether in Gaza or Sudan - tells me that the system is broken.

Continuously reminding ourselves of this is necessary for philanthropy to engage with polycrises. As a starting point, there is a need to question multiple assumptions in our approach to philanthropy and international development. To enable systems change we cannot think in terms of months, quarters, or years – these mainstream ideas around time horizons of funding will not result in lasting progress. Long-term funding of individuals, collectives, and communities is essential to create lasting impact. If the philanthropic vision is long-term, then it is necessary to think beyond immediate and tangible results. By ensuring that funding allows stakeholders to focus on the future, philanthropists can help lay the groundwork for environments where lasting progress is possible.

Linked to this is the focus on impacts, outcomes, and metrics, which are not fit for purpose. Such narrow indicators may help with measuring incremental change, but the world needs transformational change. The top-down expert-led frameworks of Monitoring, Evaluation, and Learning (MEL) are part of the same problem because they are based on the assumption that "we know what success looks like."

Perhaps, the most dangerous assumption of all is that philanthropists "find solutions," "build solutions," or "solve for" – it is crucial to recognize that the philanthropy cannot discover, evaluate, or own the answers. Philanthropists must be willing to listen to and learn from the communities they aim to serve, rather than making choices on their behalf. The biggest hurdle in this process is often ego; effective philanthropy requires humility and a genuine desire to empower others rather than seek personal recognition or legacy.

Finally, the assumption that funding or financing is a pivotal factor needs to be questioned. It is only one of many variables, for no matter how much money is thrown at climate change or mental health, they will continue to be long-term problems. Whether it is very popular giving pledges or recent commitments around health and climate, how we give possibly matters more than how much we give. I urge philanthrophy to be reflexive and ask of ourselves: how accurate are we in providing funds to the right people, and how efficiently do we make funds and resources accessible to them?

Harsh Mariwala

Note from the Editor

This is the sixth edition of ReFrame, though it is, by all accounts, late by a year. As editor, I had decided the theme for this issue well ahead of time, but was unable to write a call letter for well over a year. At the time, after seeing me struggle for many months, my colleague, and MHI CEO, told me that it was okay to not publish at all that year. This allowed me to completely stop thinking about ReFrame for months. Much later, I was able to write with the support of teammates, but I continue to struggle to reach the pace of thought or work I've maintained in years past.

It is important for me to start this off with such a 'personal' conversation because, despite regular access to a psychiatrist and counsellor, I was unable to do this work. In fact, it is due to accommodations, and due to enabling environments, that I manage to work at all. However, according to the 2018 Lancet Commission on Global Mental Health (GMH) and Sustainable Development, critiques of the dominant biomedical narrative are a threat to Global Mental Health. How is the GMH field fit for purpose if there is an overwhelming need to uphold Western psychiatric frameworks? Additionally, deemed problematic by the Lancet Commission was the idea of diverse constituencies fragmenting advocacy particularly by foregrounding discrimination. Thus, it isn't surprising that conversations around mental health at work, or around depression, anxiety, or burnout, don't consider how neurodivergent folx experience burnout. This is why I prefaced this note with a personal example.

However, even when one looks at the knowledge or advocacy around experiences of neurodivergence, they are not inclusive of those marginalised by race, caste, ethnicity, class religion, gender, and sexuality. While my experience is valid, I have many advantages in my corner – being at the top of the organisational chart, not having to factor in monetary concerns, not having to continuously prove myself due to caste privilege, etc. But how does one work towards access for all or universal health care when certain narratives, communities, and knowledge are excluded from GMH? If these omissions remain unquestioned in GMH and health equity discourse, psy-institutions will continue to reproduce systemic violence that is embedded in "everyday practices of a well-intentioned liberal society" (Iris Marion Young).

Of course, this is not new; the mental health industry has always colluded with power, particularly the colonial matrix of power. However, since GMH aims to focus on low and middle-income countries (LMICs) contexts, should it not foreground decolonisation and decoloniality? The lack of visible engagement on this has propelled my work for this issue of ReFrame. There is anger and rage as one watches the mental health industry be silent or become active participants in the dehumanisation of certain communities and nations over the last eight months.

This is very clear in the way we saw the psy-complex allying with Ukraine, versus the lack of humanity being accorded to Palestine, as well as Congo and Sudan. On the contrary, a few major psychiatric associations, such as the American Psychiatric Association (APA) and the American Academy of Child & Adolescent Psychiatry (AACAP), wrote statements against acts of terror against Israel. How is it that all the voices and clamour around youth mental health don't extend to Palestinian youth? Or maternal mental health extend to Palestinian mothers? I wonder how many formal bodies within the psy-disciplines have shown any solidarity at all for the long ongoing and current acute atrocities against Palestinians.

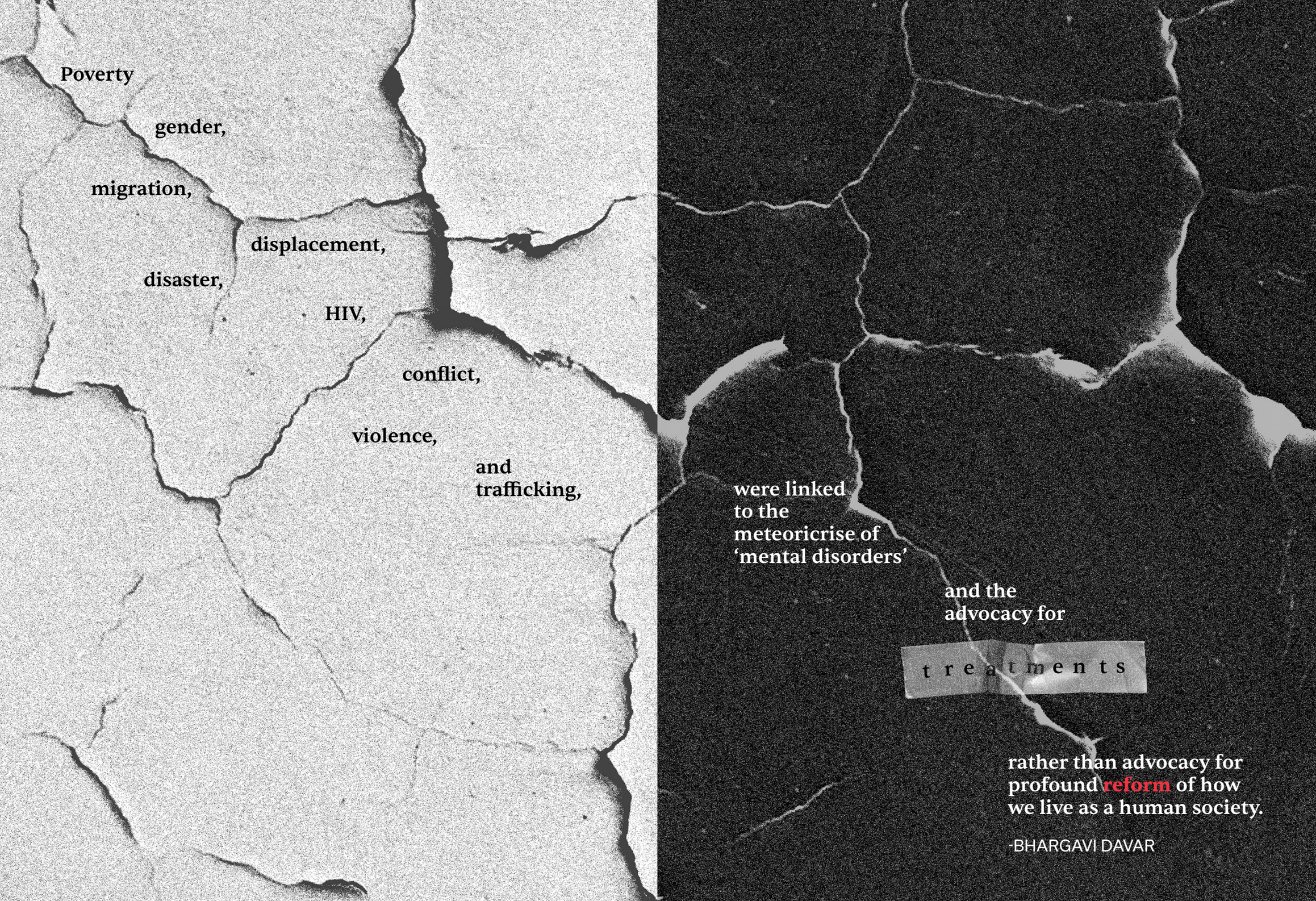
I often speak (and write) of the violence of clinical legacies in the psy-disciplines, but the last eight months have made me question whether to call it a violent clinical legacy, for the violence and weaponising of the psy-discipline under the garb of scientific neutrality is well and truly alive. Mental health cannot overlook the collective impact of colonialism and oppression on people's well-being.. As Ursula K. Le Guin writes, "It was easy to share when there was enough, even barely enough, to go round. But when there was not enough? Then force entered in; might making right; power, and its tool, violence, and its most devoted ally, the averted eye."

With this issue of ReFrame, we hope to address the averted eye in psy-disciplines, featuring scholarship from feminists from Turkish, Kenyan and Dalit movements; Mental health professionals from Palestine, Malawi, and Kashmir; and from indigenous communities across the world – Quichua, Naga, Roma community, and the Murrup Bung'allambee Indigenous Psychology group. Voices from peer support providers, trafficking survivors, and social workers in this issue detail how we can gain practical on-ground understanding of interrupting power and disenfranchisement.

You will find these essays interspersed throughout ReFrame, with section 1, 'Re-vision', featuring advocacy, perspectives, and research on livable lives, colonial trauma, and cultural negligence, neoliberal well-being, and neurodiversity. The "Contexts" section details lived experience that challenges mainstream constructs around Post-traumatic Stress Disorder, maternal mental health, stigma and discrimination, cultural sensitivity, and colonialism. Finally, "Engage" shares on-the-ground examples of research, service delivery, law, and policy on incarceration, collective healing, trauma-informed approaches from marginalised communities, health equity, and digital medicine.

With this issue, I hope that we all continuously confront suffering in ways that are intersectional and collective, while also centring context, resistance, compassion, and solidarity.

Raj


Poverty
gender,
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meteoricrise of
'mental disorders'
and the
advocacy for
treatments
rather than advocacy for
profound reform of how
we live as a human society.
-BHARGAVI DAVAR

How

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?

How has the Global Mental Health (GMH) field reacted to critique regarding its relevance in tackling mental health issues worldwide?

How do we understand resilience when it comes to oppression that is both historical, intergenerational and day-to-day? What is the role of the GMH field 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 and psy-activism, and acknowledge both the risks and resilience in resistance?

What

REVISION

What does it mean to 'decolonize' the Global Mental Health (GMH) field?

ADVOCACY
PERSPECTIVE
RESEARCH


Contesting
GLOBAL MENTAL HEALTH
RAJ MARIWALA, SANIYA RIZWAN AND AMALINA SENGUPTA
Disrupting
Knowledge
and
Power Systems

GMH — Global Mental Health

LMIC — Low and middle-income countries

MGMH — Movement for Global Mental Health

PWLE — People with lived experience

Introduction

Global Mental Health (GMH) emerged in 2007 with a Lancet series that called for increased mental health services in low and middle-income countries (LMICs). The series was authored by academics and researchers affiliated with organisations such as the World Health Organisation (WHO), the World Bank, and universities, primarily in the Global North.[1]

A decade later, the Lancet Commission on Global Mental Health and Sustainable Development reviewed the field's progress, emphasising the need to scale up services, address social determinants, and leverage digital technology. Most Commission members were Global North experts or academics, with only one user-survivor voice.

The 2018 Commission noted progress in closing treatment gaps in LMICs and doubling mental health support but also recommended expanding services, addressing social determinants, adopting digital tools, and developing public policies.[2]

These threats included the limited impact of clinical treatments and rising adverse social determinants. Notably, one of the identified threats was the critique of the dominant biomedical narrative and Western psychiatric framework.

From the field's inception in 2007 to the present in 2024, the same voices—affiliated with elite American and British universities, organisations, journals, and funders—continue to dominate, reflecting Euro-centric biomedical narratives.

Post the COVID pandemic, there has been growing attention to mental, public, global, and planetary health.

In this edition, we examine how GMH pillars have adapted to threats including global upheavals like

Critiques and Crises

The field of Global Mental Health (GMH) has gained prominence but also faced criticism. Critics such as China Mills and Bhargavi Davar (2016) pointed out its dominance by Global North expertise and methods.

> "MGMH [The Movement for Global Mental Health] is increasingly functioning as a global space that shapes the contours of what can be said [...] The Movement's calls 'to make mental health for all a reality' serve to make mental health as a reality thinkable in certain ways that are dominated by ways of knowing and intervening upon distress which come from the global North."

Additionally, anthropologists have critiqued the field for repeating colonial dynamics wherein practices and systems from Western contexts are pushed upon culturally unique countries and regions.[3]

A key critique is the field's focus on 'scalability' and 'treatment gaps' in LMICs, equating distress with mental health disorders while overlooking the critical impact of socioeconomic inequalities.[4] Socioeconomic and sociopolitical factors like war, occupation, poverty, rising unemployment, and gender-based violence cause natural reactions of distress, which GMH often pathologises (depression, for instance), offering medical solutions for complex, non-medical problems.[5]

Additionally, nuance is often lacking in 'expert'-led discourse on GMH; while raising awareness and improving access to mental health services is important, the reasons for access barriers—such as travel distance to find a practitioner or a lack of cultural and structural competency in training—are rarely explored, often leading to pathologisation and harm to users. [6], [7]

The GMH field appears disengaged from unfolding global crises. The Gaza genocide has persisted for nearly a year, claiming thousands of Palestinian lives yet leading mental health bodies and journals have issued statements supporting Israel or focusing on the war in Ukraine. Sub-Saharan Africa's 49 countries, with borders drawn during 18th and 19th-century colonisation, face ethnic tensions, and resource disputes, leading to conflict and humanitarian crises. Colonial extractivism and climate change exacerbate instability, with

35 conflicts in 18 countries displacing nearly 39 million people.[8]

The mental health implications for affected communities impacted by international development dynamics are rarely discussed.

The GMH field often frames distress as symptoms of psychological disorders that can be treated using Western methods like talk therapy and psychiatry while overlooking the effects of intersecting power systems such as capitalism, patriarchy, authoritarianism and colonialism.[9] Despite the ongoing critique,[10] the field still emphasises a "unidirectional" flow of resources and attention from affluent, Western countries to address mental health in LMICs in the Global South.

LMIC Poster Child

Global Mental Health views the world through national units, assuming each nation has a homogenous culture and is either powerful or powerless based on its location in the Global North or South.[11] This approach oversimplifies the complexity of Global South communities, ignores internal power dynamics, and overlooks diverse mental health needs, and the impact of neoliberal policies.

GMH fails to account for the complexity of the 'Global South' and its material realities, which are shaped by power dynamics beyond the Global North-South binary.

Even within this framework, GMH often overlooks the ongoing impact of neoliberal dynamics and focuses instead on the perceived lack of service delivery from Western mental health systems to the 'underdeveloped' world.[12] GMH then consequently and often unknowingly conceptualises Global South as an unresponded (singular) customer of the modern healthcare service.

This leads to failures in understanding the varied mental health needs of diverse communities in LMICs, their domestic-regional geopolitics, and the layers of embedded power systems.

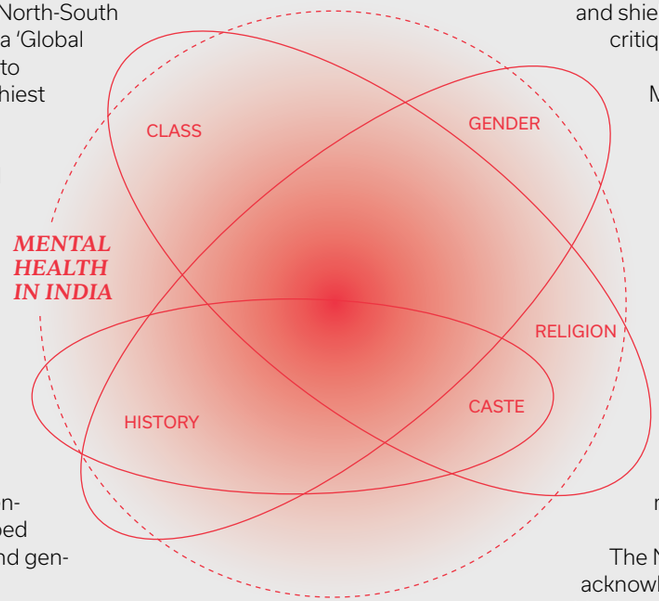
Consider India within the North-South binary: while classified as a 'Global South' country, it is home to some of the world's wealthiest individuals and a political elite, with a complex economy driven by neoliberal desires and demands. [13]

The mental health needs of Indians differ from the West and cannot be singularly defined by a 'Global South perspective.

As this volume's essays will demonstrate, mental distress and access to mental health in India are shaped by caste, class, religion, and gendered identities.

'Indian' perspectives of GMH are largely dominated by upper caste academics and professionals,[14] neglecting the social determinants affecting the majority-deprived of adequate housing, sanitation, food security, dignity and health-care, and are vulnerable to cli-mate disasters and forced migration.

Their mental health needs require structural and social reorganisation within India, not just the upscaling of modern psychiatric medicine.



GMH's call to incorporate 'Indigenous' knowledge systems[15] is well-intentioned but overlooks the complex politics of indigeneity... In India, 'indigenous' can refer to tribal, Adivasi communities or be used to promote divisive insider-outsider narratives, fuelling communal conflict whereby Muslims and Christians are not seen as fully worthy of citizenship. Labelling Hindu culture as 'Indigenous' reinforces the Brahmanical caste order and shields it from the 'modern' critique.[16], [17]

Marginalised castes, religions, and ethnicities face both material and psychological oppression within a socio-economic structure shaped by India's global position and social fabric.[18]

Thus, no single "Indian" perspective or knowledge system can adequately capture the country's diverse mental health needs.

The North-South divide acknowledges a colonial history, positioning the South as less powerful. This framing, however, overlooks the South's own colonial ambitions and oppressive systems. India's treatment of the North East and Kashmir, including militarisation, profit-driven projects, and the suppression of local voices, has caused a severe mental health crisis over decades.[19]

For GMH to effectively address mental health in LMICs, it must critically examine and move beyond these binary divisions. Critiques of mental health service delivery, framed by the West-East or North-South divide, often end up reinforcing the very dominant perspectives they aim to challenge.

Experts by Experience

There has been a gradual shift to decentre biomedical psychiatry in Eurocentric discourse. In GMH, this is reflected in the 2018 Lancet Commission, which included one user-survivor voice, and the formation of the Global Mental Health Peer Network (GMHPN) the same year.

Grassroots movements led by survivors challenge the mental health system, exposing violence both within and beyond it. They aim to reshape the system from the ground up, not just prevent harm. Resistance to individualised biomedical discourse has long existed, as seen in the Scottish Union of Mental Patients,the Insane Liberation Front in the 1970s, Asylum Magazine (1986), and the Aaina newsletter (2001).Similarly, Mad Pride, Mad Studies, and crip activism connect psychological distress to socio-political oppression and violence.

However, as the movement(s) are not homogenous, it is crucial to recognise who speaks from lived experience in GMH. Whether it is in clinical research, academia, services or as consultants for funders, the focus is on People with Lived Experience (PWLE) who may identify as 'patients,' 'service users,' or 'experts by experience'.[20]

For instance, the Lancet Commission typically includes those who accept the medical model and advocate for reform within the system. Partnering with mental health professionals gives PWLE credibility and visibility, but risks co-opting their knowledge and political ideals of user-survivor movements, situating them within profit and efficiency paradigms.This perpetuates an individualised, decontextualised, cure-based, neo-liberal lens maintaining the power gap between medical experts and those with lived experience.

Currently, lived experience in GMH is defined by diagnosis and engagement with formal mental health institutions.

Is this truly representative of the majority world?

What about those in countries with no services or significant treatment gaps?

Can someone be considered a valid PWLE without access to a diagnosis?

IT IS CRUCIAL TO RECOGNISE WHO SPEAKS FROM LIVED EXPERIENCE

By narrowly focusing on carceral institutionalisation and asylum frameworks, GMH centres on discrimination within these systems, neglecting the broader social determinants of mental health. This limited scope overlooks areas where biomedical intervention isn't central to the discrimination faced by those with psychosocial illness or distress.

By not including those surviving systemic discrimination embedded into health systems this perspective limits the term 'lived experience' to be used in the contexts of queerness, race, caste and other historical marginalisations. Especially, in the LMIC context, this means that PWLE often speak from privileged positions of caste, class, language and geography which affects their access to diagnosis, discourse and formal mental health services.

This issue is also evident in the Global North, where only certain voices shaped by race, religion, ethnicity, and gender and sexuality, are valued. For instance, it took George Floyd's murder for the American Psychiatric Association (APA) to finally recognise and apologise for its role in supporting structural racism affecting Black, Indigenous and People of Colour communities.[21]

Additionally, activist movements like neurodiversity face the same challenges as institutionalised approaches to lived experience, struggling with similar issues of representation and validation.

Disability and Decolonisation

The call to decolonise GMH has been made for over a decade but is only now gaining traction.[22] To challenge GMH's colonial roots, we must recognise that it perpetuates structural violence by upholding psychiatric definitions of normalcy and productivity, often serving neoliberal interests. This paradigm excludes and dehumanises populations based on their socio-political and economic realities. Notably, prominent voices and funders of GMH remain silent on Congo and Gaza highlighting the dominance of Western knowledge and power hierarchies.

This must be examined intersectionally through Indigenous perspectives, mad studies, crip theory, and critical disability studies. However, the challenge arises when people's movements are also implicated in this colonial framework.

Originating from autism advocacy, the neurodiversity movement initially missed crucial intersections like race, sexuality etc. Neurodivergence is often seen politically but lacks depth when limited to white, able-bodied perspe-ctives, leading to advocacy efforts that reflect only a specific group. This narrow focus contributes to the disproportionate police violence and murder of Black youth and adults with mental illness in the United States.[23]

When examining neurodiversity globally, we must ask how it manifests in historically marginalised communities and regions, and whether it includes systemic, biomedical, political, and relational factors.

In decolonising mental health, counter-narratives rooted in lived experiences challenge dominant paradigms, serving as both stories and critiques of what is currently seen as progressive approaches. Decolonisation is political, involving frameworks, accountability, and power structures. It requires recognising how colonisation has shaped bodies and minds, including the assumptions about them, and connecting this to experiences in colonial or postcolonial contexts. Failing to address how colonisation created and defined disability risks perpetuating colonial narratives in discussions about disability.

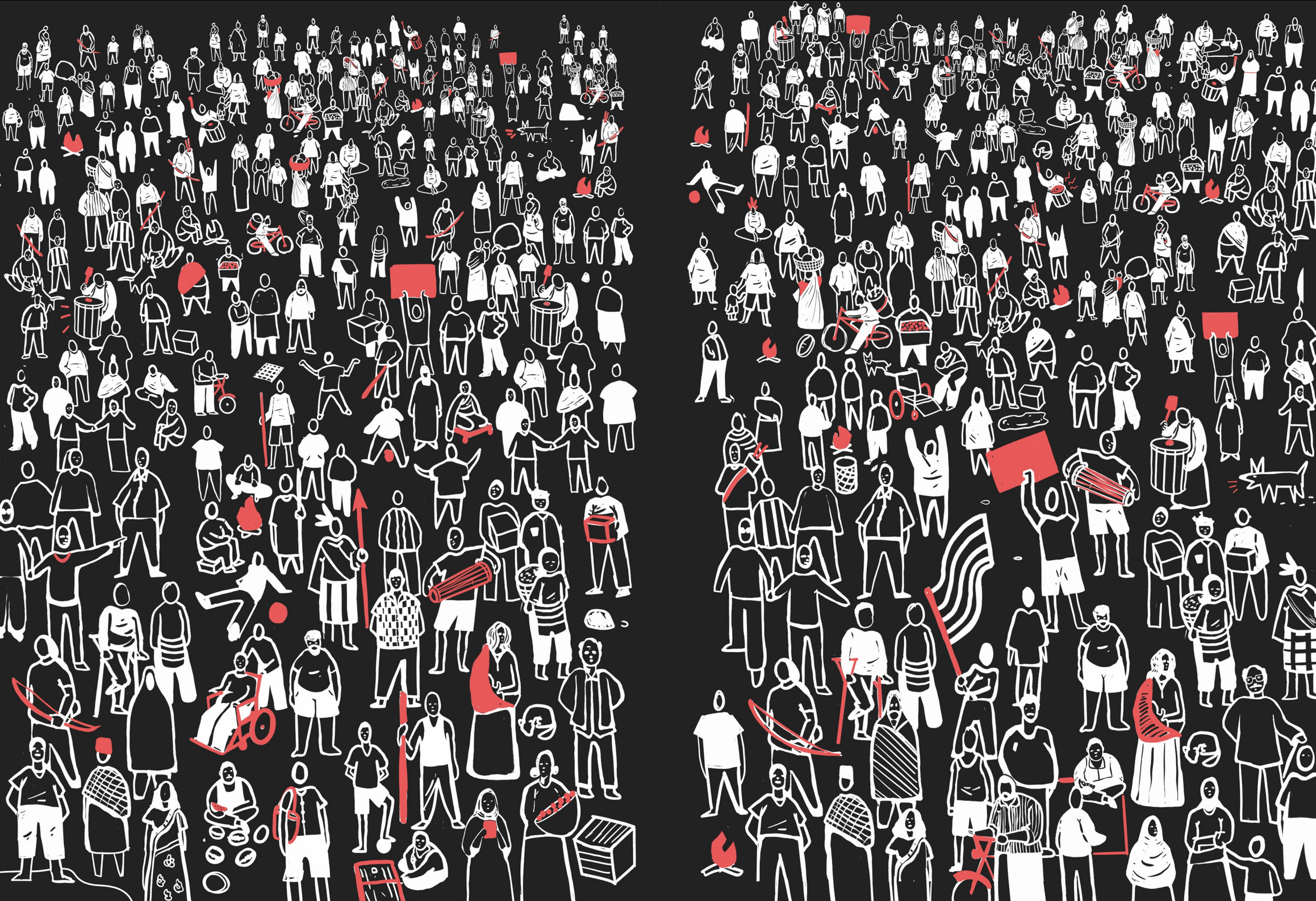
It is crucial to challenge the dominant decolonisation narrative by disabling it. This means recognising that the current framework fails to consider how both colonial narratives and Global South elites have impacted individual and collective bodies.

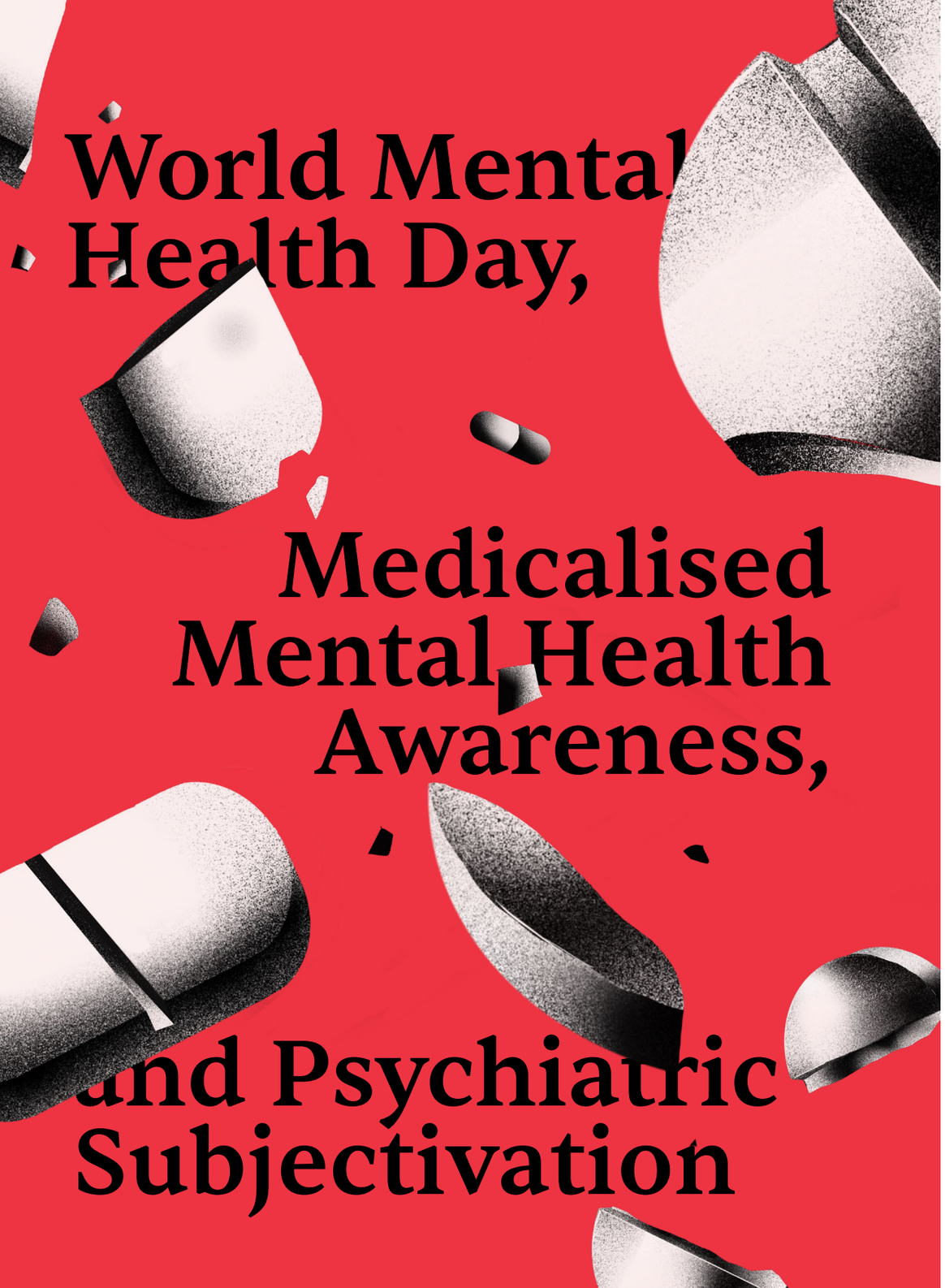
By centering the language of disability, GMH and other fields must acknowledge the ongoing colonisation of disabled bodies and colonial and postcolonial factors in shaping disability.

Raj Mariwala is Director, MHI.

Saniya
is a sociologist, currently working as an Associate (Mitigation) at Project 39A NLU, Delhi. Through her research and writing work, she engages with discourses on law, nationalism and governance with a keen focus on climate politics and disability.

Amalina
has an educational background in psychology and social science. She is currently a training associate at MHI, and is involved in the administration, impact assessment and research related to MHI's various training programs on gender-sexuality and organisational diversity and equity.





Stories and Anxieties of 'Unlivability'

SUDARSHAN R. KOTTAI
New Delhi

I met Aparajita (name changed), diagnosed with 'mental disorder', at a shelter home in Assam for my fieldwork. Describing her husband as 'a dangerous beast devoid of love', she pointed to the scars he had inflicted on her. 'I have made so many friends at the shelter home, and I don't wish to leave.' This hesitation to re-enter the world outside speaks of exclusions, voice poverty, and the domination of patriarchal norms in her lifeworld, which are intertwined with her mental well-being. However, such upstream factors of suffering and 'enforced unlivability', as defined by Judith Butler,[1] are almost always excluded by the hegemonic, unidimensional definition of 'mental disorder' imposed by mainstream mental health systems.

The World Mental Health Day, marked every year in October, is primarily used to generate 'awareness' about the increasing prevalence of 'mental disorders', with the mental health infrastructure bombarding the public with staggering statistics on rising rates of depression, anxiety, and other mental 'disorders'. The risk mongering that one in every eight people suffer from 'mental disorder' has been addressed by increasing accessibility to mental health services to cure the 'epidemic' of mental illness, without any intention of preventing suffering.[2] Nikolas Rose meticulously explains 'governing at a distance' that relates to risk-thinking in contemporary psychiatry – the new ways of working in terms of risk assessment and risk management strategies that shape the conduct of mental health professionals and types of judgements they make.[3] Any deviance from the 'normal' and established social morality almost always attracts psychiatric surveillance and control. As a consequence, people whose mental well-being is affected are not encouraged to introspect on larger sociopolitical phenomena and structural inequity that cause and perpetuate mental distress.

Mainstream mental health discourses, including awareness campaigns, make people believe in distress being personal and in the ability of professionals to churn out 'mental health' in people through therapies and medication. The promise of psychopharmaceuticals is given to lift people from distress and make them 'confident', 'socially skilled', and 'happy-go-lucky'. Thus, medicines not only relieve distress but also invoke the quest to attain 'mental health', which Stefan Ecks refers to as a 'monoculture of happiness'.[4] He evidences a continuing shift towards capitalist commodification through pharmaceuticalisation in the context of rising diagnoses of depression and the prescription of a wide range of mood medications. Psychiatric discourses impose social control by shaping the way we imagine ourselves, our relationships with others, and our problems and solutions to them.

The Mental Health Paradox

The movement for global mental health kickstarted with an article in the Lancet in 2007. It argues that while about 30% of the global population suffer from some form of 'mental disorder', only one-third among them receive treatment, leading to a mental health gap, and points out the urgent need to 'scale up' mental health services.[5] The movement has expanded as of 2024 to a network of 200 institutions and 10,000

individuals seeking enforcement of 'right to mental health' in low- and middle-income countries. As these become the dominant mental health discourses of governments, institutions, and laypersons, interventions are almost always synonymous with increasing professional mental health services, which exclude locally sustainable and culturally appropriate approaches and solutions.

In India, there are more psychiatric social workers, psychiatrists, clinical psychologists, and psychiatric nurses than ever before, thanks to the increased production of mental health professionals in response to this call.[6] We now find them not only in mental health centres but also in schools, family courts, IT companies, police and military establishments, etc. However, mental health concerns are also said to be increasing, despite the aggressively expanding services to address this.[7] This raises questions on the quality of these interventions and shows that the actual underlying structural causes are going unaddressed.[8]

Historically, mental health professionals have aligned with majoritarian power structures to perpetrate violence on the most vulnerable.

The American Psychiatric Association and American Psychological Association in 2021 tendered public apologies for inculcating racism in psychiatry and psychology respectively.[9] Dainus Pūras, the first psychiatrist to be appointed as UN Special Rapporteur on the Right to Health and Mental Health, in his several reports submitted to the UN General Assembly, lays emphasis on the need to shift towards rights-based mental health systems and away from the dominant biomedical model.[10] The reports are critical of the mental healthcare infrastructure for using 'biased' evidence that favour biological interventions, contaminating the knowledge base in mental healthcare (such as pharmaceutical companies withholding negative results of drug trials), and overprescribing medicines. The reports also warn that power and decision-making in mental healthcare are often concentrated in the hands of 'biomedical gatekeepers' and also highlight the 'lack of transparency and accountability in the relationships between the pharmaceutical industry and the health sector, including academic medicine'.

Vanishing Stories and Anxieties of 'Unlivability'

The stories of life struggles, desires, anxieties, diverse ways of being in the world, and alternative paradigms are missing from the World Mental Health Day awareness campaigns. For women like Aparajita, these campaigns evade the collective responsibility of ensuring conditions of 'livability'. Butler describes 'livable life' as 'to be able to dwell as a body in a world that is sustained and safeguarded by the structures (and infrastructures) in which one lives'.[11]

Interventions that hesitate to advocate for a 'livable life' establish profit-making mental health systems that produce 'patients' by medicalising social suffering and structural violence.[12] Ethics and values are dented when socio-structural determinants of mental ill health – such as inequality, inequity, invalidation, invisibilisation, loss, patriarchy, poverty, unemployment, and discrimination based on age, body image, caste, class, disability, gender, gender identity, sexual orientation, and so on – are footnoted during the World Mental Health Day celebrations. Instead, mental health concerns are often reduced to brain and chemical imbalances.

For instance, in India, mainstream mental health systems have consistently failed to consider the socioeconomic roots of the epidemic of farmer suicides.[13] Even though upstream factors that perpetuate farmers' suffering, such as the role of the State in promoting agro-capitalism, are discussed extensively by scholars and activists, mental health discourses almost always frame it as an individual problem, situating solutions in psychopharmaceuticals and individualised psychotherapies. Social suffering is thus reframed as individual mental pathologies. People from the mental health infrastructure in India have not spoken against their own fraternity discriminating against and perpetuating violence on marginalised communities – for instance, the notorious 'conversion therapy' that mental healthcare professionals targeted at LGBTQI+ individuals, medicalising societal prejudices and reinforcing structural violence. This did not receive attention till the Madras High Court banned the practice in a landmark judgement in 2021. These indicate that mental health movements are small-minded and mimic socio-moral norms in dealing with human rights violations by separating themselves from other movements.

Cure Has Limits but Care Doesn't

Mental healthcare, especially for marginalised people, should be cognisant of structural inequalities. It should incorporate inter- and multidisciplinary treatments based on empathy, unique historicities, and power imbalances. Mental healthcare professionals should mark not only World Mental Health Day but also Constitution Day, Human Rights Day, Transgender Visibility Day, and so on, to appreciate intersectionality. As one of my interlocutors, a community volunteer in the pain and palliative care system in Kerala, told me, 'Cure has limits but care doesn't.' I return one final time to Aparajita, who spoke of love for humanity as a whole. We are witnessing commodification, commercialisation, and dehumanisation of mental healthcare. Her ideas need wings to catapult an inclusive, pluralistic, and onto-epistemically satisfying mental healthcare ecosystem which archives lived experiences, for, Ann Cvetkovich argues, archives 'must preserve and produce not just knowledge but [also] feeling'.[14]

Sudarshan R. Kottai
serves as an assistant professor in the Department of Humanities and Social Sciences, IIT Palakkad and is a distinguished fellow at the Centre for Equity Studies, New Delhi. Trained as a clinical psychologist, his research focuses on 'modernising' mental health systems in the Global South and their relationship with the wider social world.

Authoritarian Neoliberal Regimes and Global Mental Health

Reframing Well-Being through Feminist and LGBTQI+ Perspectives

BEYZA BILAL & GÜLNUR ELÇIK
Turkey

Illustration: Deepti Sharma

Introduction

Through the twenty-first century, populist right-wing leaders and competitive authoritarian regimes have been on the rise in different countries. The regimes we live under have a direct impact on the biopsychosocial well-being of individuals and communities. It has been shown that authoritarianism has a direct impact on mental health: they may lead to depressive symptoms, internalisation of oppression, externalisation of self-blame, insecurity in social relations, decrease in sense of safety and control, and hopelessness.[1]

Authoritarian regimes also tend to be heteropatriarchal regimes – a sociopolitical system in which cis-heterosexual males have power over all other identities of gender and sexualities – further influencing mental health through gender inequalities, discrimination and violence, and marginalisation and stigmatisation, all these also intersecting with class, racial, and ethnic identities[2]. Therefore, interventions for global mental health need to take into consideration the power inequalities and social injustices of authoritarian and heteropatriarchal regimes. This paper examines how women and LGBTQI+ communities under such regimes can reclaim their mental health rights, which would also involve freedom from oppression, and how their experiences, strategies, and knowledge can help reframe global mental health norms.

Authoritarian Neoliberalism Relies on Neoliberal Well-Being

The impact of authoritarian regimes can be further understood in the context of the neoliberal economies in play today. How does authoritarian neoliberalism impact our daily existence? What is it like to be someone who is the bearer of an ideology or identity that is directly and uninterruptedly under its attack?

Authoritarian neoliberalism can be roughly summarised as the authoritarian accumulation mode of neoliberalism. It is aptly called 'reverse hegemony',[3] and it relies on a strategy in which the moral direction of society is seemingly exercised by the poor, yet an attack on workers' rights is simultaneously in place for the benefit of the bourgeois class. Authoritarian neoliberal regimes are driven by a power bloc that ironically brings together large parties of the ruling and working classes within a conservative, anti-feminist, anti-LGBTQI+ context.[4]

The power blocs of these regimes need the people to be impoverished and incapacitated in order to rule over them without resistance.[5] An authoritarian neoliberal regime weakens voters – both as individuals and as members of society – intellectually, mentally, and physically. The more people are impoverished mentally and intellectually, the more they cling to the conservative government to protect them against perceived threats from 'progressive' groups such as the LGBTQI+ community or women's rights groups.

Moreover, this regime promotes only a neoliberal well-being, while eliminating all other societal and political grounds of well-being. Neoliberal well-being reduces problems and solutions to an individualistic level. It triggers excessive self-love, but that which is in conflict with 'being friends with yourselves'.[6] It suggests people take an anti-political stand for the sake of their wellness. All the more, it suggests a default pattern that supposedly can be applied to everything, whether one is a gay person ostracised from the traditional family, or a worker with a twelve-hour workday, or a political activist facing societal and political threat. It serves only one category of the public, the bourgeoisie, and provides unidimensional, heteronormative suggestions to be applied to varied problems for varied classes of population. Summarily, neoliberal rendering of well-being intentionally overlooks those who fall outside of the normative frame.[7]

Norms: Authoritarian and Patriarchal Regimes, Global Mental Health, and Feminist Perspectives

Authoritarian regimes employ multifarious methods to sustain their use of power, some of which correspond to the psychosocial sphere of society. They induce insecurity among certain subgroups of society, while providing illusional security for others, and they dredge up uncertainty by creating a situation of deteriorating social norms. In order to gain social control, on the one hand, these regimes reconstruct and mainstream norms that are considered normative among groups they wish to please – for instance, queerphobia. On the other hand, these patriarchal and misogynistic regimes do not hesitate to twist and misappropriate progressive politics to suit their agenda. These are two sides of the same coin. On the one side, an authoritarian regime may target women and LGBTQI+ people. For instance, Javier Milei, the current president of Argentina, is virulently against abortion rights, and he also shut down the Ministry of Women, Gender, and Diversity.[8] Russia's top court banned what it calls the 'international LGBT public movement' in November 2023.[9] On the other side of the coin, the authoritarian regime also uses gender politics as a strategy to legitimise itself, which is called gender washing and democratic backsliding.[10] For example, in Algeria and Mozambique through NGOs,[11] or in Turkey through political party discourse.[12] For this reason, it is key to understand how authoritarian and patriarchal regimes operate through the 'norm', 'normal', and the 'normative', and its relationship with individual and community mental health.

Conclusion

Given the personal is political, to prevent the underrepresentation of lived experiences of women and LGBTQI+ people in global mental health as well as to avoid overlooking historical and structural power inequalities, there is a growing discussion to reframe the norms of mental health and psychosocial interventions,[13] mental health policies, standards and norms,[14] and science and research.[15] Throughout the history of psychological sciences, various feminist and queer interventions have transformed existing norms of mental health. One example is the reframing of trauma and trauma theory through the struggle and hard work of the feminist movement on sexual and gender-based violence.[16] Another example is the reframing of gender identity disorder in international diagnostic manuals, such as in both the Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5) and the International Classification of Diseases-11 (ICD-11),[17] which the trans movement brought about through the Stop Trans Pathologisation 2012 campaign.

But there is still a long way to go, given the effects of structural inequalities and oppressions on the mental health of women and queer people. There are efforts to reframe the norms of global mental health by fostering new lenses in terms of equality, inclusion and diversity, decolonisation of the body, labour and care, intersectionality, and freedom from violence.

The very existence of queer people becomes a radical act against authoritarian regimes, as lesbian, black activist, and poet Audre Lorde has emphasised.[18] Therefore, instead of chasing a neoliberal interpretation of well-being, LGBTQI+ and feminist communities should build the ideas of queer political well-being. As a mechanism of self-protection, especially against the oppression of authoritarian institutions, it is also necessary to acknowledge our mutual dependency as members of an organisation, movement, or community. Transcending one-dimensionality – which is suggested by a masculine way of politics and organising – and encouraging reparative perspectives in our relationships seem to be indispensable to our individual, intersubjective, organisational, and societal well-being. All these measures transcend the dichotomic understanding of politics, organising, and life itself. Instead of reacting to the daily developments, a responsive approach which allows us to see how an alternative family, organisation, community, society, and world which is not deprived of the LGBTQI+ and feminist perspectives would thrive, is crucial.

Beyza Bilal
from Istanbul, Turkey graduated from the Psychology Department, Boğaziçi University in 2011 and has been working for NGOs since 2012 in various roles, with special interest in mental health and feminist policies.

Gülnur Elçik,
from Bursa, Turkey is a feminist and socialist activist. Her PhD thesis was on the organisational politics of the political parties in Turkey. Currently she is working at a civil society organisation, focusing on community resilience and care-based politics. She has also been a freelance trainer on gender equality and freedom, labour rights, and care-based organising for more than 15 years now.

Illustration: Keisha Thomason

Enough Politeness: Decolonising Mental Health in a Society Oblivious to Its Colonial Wounds

How to Transform Mental Health through Confronting Colonial Legacies in Health Discourse

CAMMI MURRUP-STEWART & MADELINE WILLS
Australia

The Science behind Colonial Trauma

As Aboriginal women, we have had enough of the polite silence that masks the deep wounds society continues to inflict upon our culture. The prevailing mental health discourse, chained to a Eurocentric biomedical model, undermines our cultural practices and pays no heed to the ongoing colonisation that bleeds into every aspect of our lives.

In October 2023, Australia held a referendum seeking constitutional recognition of over 65,000 years of Indigenous culture as well as advisory representation and government.[1] As the only colonised nation without a formal treaty or comprehensive agreement with its First Peoples, Australia – a British settler colony that colonised over 250 Aboriginal and Torres Strait Islander Countries – continues to struggle with its coloniality. Declining media integrity, globalised politics, and social media echo chambers shape public debate in the country. As a consequence, more than 60% of Australians opposed the suggested constitutional changes.[2] Having national debates on topics such as recognising the First Peoples of Australia, places communities in a vulnerable position, often producing fatal mental health consequences. Even within weeks of our collective grief at the fact that more than 60% of our neighbours voted against our rights to inclusion and representation in our own country, many First Nations people in so-called-Australia had to switch focus from our local struggle with ongoing colonisation to the global reality of horrifically violent colonisation and genocide in Gaza.

While we oscillate between despair and rage, meeting with our therapists to unload some of this burden, we cannot help but see this as an unveiling of the ongoing colonisation, hidden behind capitalist success

and democratic 'civilisation', to reveal the ugly truth of our world. Indigenous Peoples have known this from the beginning. Colonisation and its various gaudy costumes – patriarchy, capitalism, racism, ableism, and environmental exploitation – continue to perpetuate systemic inequalities and injustices, deeply impacting the well-being of those living under its iron boot. Healthcare systems are only another piece of this puzzle.

Biomedicine's Cultural Negligence

The biomedical mental health model, long dictating mental distress understanding and treatment, neglects colonial trauma's impact.

Why are natural human responses to stressors like climate change, war, poverty, isolation, and oppression – such as anxiety, depression, and even psychosis – pathologised?

Why are we labelled as disordered when we react to the disorder around us? Is it not natural to feel despair when our phone is full of images of innocents dying, of our lands burning and flooding, of pandemics forever altering our reality, and of the rise in hatred and disunity? If we consider what a healthy response to the crisis is, then perhaps we can see the decline in global mental health as a legitimate reaction to our environment. Humans are meant to grieve. We are built to live in connection with one another, and when disconnected, we are fundamentally not whole – we are unhealthy. Pathologising natural responses to near-constant existential threats does no one any good. Instead, what this does is direct attention to vulnerable communities who sit unwillingly at the hands of ongoing colonial power, leaving oppression unexamined. Our reactions are not symptoms of personal failings but responses to a society that continually fails us. We must transform to understand and radically address the root causes of our pain.

Marginalisation of Indigenous Healing

Recent shifts in scientific thinking towards recognition of 'social' causes of health challenges[3] overlook existing Indigenous perspectives on colonial causes of mental distress. Colonisation has brought with it an imposed and false concept of Western scientific superiority. Waves of genocide, assimilation, and cultural erasure have not only marginalised but also actively oppressed non-Eurocentric knowledge systems, labelling them as 'other', 'alternative', or 'lacking in rigour and validity'. This biased view has invalidated centuries of Indigenous wisdom and healing practices, reducing them to footnotes in the dominant narrative of healthcare and causing irreparable harm to the mental health of Indigenous Peoples. Within this context, the Eurocentric biomedical model of mental healthcare falls significantly short, failing to address the myriad cultural, spiritual, and communal factors essential to the mental well-being of humanity itself.[4] The societal structures around us – capitalism, the lingering poison of colonisation, systemic racism – are not just a backdrop; they are active contributors to our mental distress. However, Edward Said's critique[5] exposes a 'mental Orientalism' at play when attempts are made to find 'alternative' mental health models. Indigenous practices are exoticised, 'fetishized, decontextualised, commodified and repackaged for global markets by white brokers',[6] further eroding cultural integrity.

A Call for Sovereignty

Therefore, despite the allure of Indigenous cultures as a simple 'solution' that can light the way towards a more promising horizon, we must be vigilant against exoticising Indigenous and non-European approaches to mental health. This involves moving beyond seeing these approaches as merely 'alternative' or 'exotic' and instead recognising them as legitimate and complex systems in their own right that can, and should, guide Indigenous health, well-being, and healing. This is where Chelsea Watego's notions of sovereignty[7] challenge the complacency bred by placing hope in failing systems, advocating for a reclamation of our right to define wellness on our terms. Sovereignty empowers our communities to define our own health practices, grounded in centuries of wisdom and understanding.

Reimagining Well-Being

We must extricate ourselves from the false promises of homogenous colonial capitalist ideas of mental health. To achieve this effectively, we must understand and contextualise Indigenous and non-European mental health practices within their own cultural, historical, and social frameworks. This contextualised, holistic view of well-being offers not just alternatives but also necessary corrections to the narrow biomedical model. At the heart of this is human connection – the powerful healing that comes from community, from knowing we are not alone, and from cultural practices that bind us to our respective histories and identities. Change must recognise that cultural practices are not static but dynamic and evolving. Recognising the context of capitalism while simultaneously respecting values inherent to Indigenous beliefs, we can see ourselves as more than cogs in a productivity machine; we need space to breathe, to heal, and to connect with our roots. We need to be.

We are done being polite. Decolonising mental health is not a gentle reform; it is a radical overhaul, both personal and systemic. It is about dismantling systems that silence and oppress us and about building a future in which sovereignty, cultural practices, and holistic well-being, as defined on our terms, are at the forefront. But don't be misdirected further. Although this pursuit of overhaul sits with us as we unwillingly tread water in the ongoing colonial oppression, the responsibility can and must fall on the complicit colonial society. This reminds us of Tuck and Yang's arguments about 'settler moves to innocence',[8] highlighting the cognitive dissonance in non-Indigenous societies that fail to confront their complicity in these ongoing injustices.

In a world often dominated by noise, complexity, an endless pursuit of more, and increasing disconnection, we must return to the simple yet profound ideas of connection, kindness, and caring for both the earth and each other. These might sound like simple ideas, maybe even fluffy, but in the context we find ourselves, this shift in priorities demonstrates a radical reimagining of our future.

Cammi Murrup-Stewart
is an Aboriginal woman, cross-cultural researcher, and lead of the Murrup Bung'allambee Indigenous Psychology Group, Monash University. Her research focuses on the social and emotional well-being of Aboriginal youth, equity, centring the voices of marginalised peoples, and supporting connection and strong identities to improve well-being.

Madeline Wills
is a Warramungu Aboriginal woman, mental health practitioner, and community engagement officer with the Murrup Bung'allambee Indigenous Psychology Group, Monash University. Mady's work and research focus on improving Indigenous youth's mental health, digital tools for well-being, and fostering cultural safety.

Work with us, Not against us.

Neurodivergent Clients' Perspectives on Neurodiversity-Affirming Therapeutic Practices

FARAH MANECKSHAW & AMISHAA GUPTA

Bengaluru

Historically, within the field of therapy, there have been attempts to pathologise and then 'fix' or 'cure' any characteristic or behaviour that does not fit the dominant idea of 'normal'. Neurodivergent people have routinely been excluded from such key conversations that impact their lives.[1] The neurodiversity movement challenges this pathologising discourse by advocating for the recognition and acceptance of diverse identities as part of natural human variation and by standing for the rights of all.[2] It has begun to inform the skills and knowledge of therapists to foster supportive rather than 'othering' practices.[3] However, there is only limited literature on neurodivergence-affirming therapy practices from the perspective of neurodivergent clients, especially in India. Since lived experiences that come from local communities seldom enter global mental health discourse, they are often sidelined while designing interventions.[4]

The purpose of our research is to explore which particular practices in therapy are or are not experienced as affirming by neurodivergent clients and how these practices influence their lives. We undertook qualitative, semi-structured interviews with nine neurodivergent adults from India who were experiencing neurodiversity-informed practices in individual psychotherapy. Participants were required to self-identify as neurodivergent (within this umbrella, clients also identified with specific labels like being autistic, ADHDers, etc., or having dysgraphia, OCD, etc.,) and to have been in therapy for at least twelve sessions. Several of our participants identified as queer and non-binary as well.

A limitation of the study is that people who have access to therapy and the language of neurodiversity are also likely to carry caste and class privileges. Further research needs to be done to address these gaps. The field of global mental health too notes that no model of disability may be universally applicable.[5]

Neurodivergence and Mental Health

In a world designed for neurotypicals, neurodivergent people experience various mental health concerns.[6] Many of the people we interviewed spoke about feeling like an imposter or 'not normal' their whole life because of struggling with things that were 'supposed to be easy', like remembering things, paying attention, interacting with people, or doing chores. Such neurotypical expectations led to mental health concerns, made them more vulnerable to abuse, and caused other difficulties in relationships. These experiences can be conceptualised using the 'minority stress model', which attributes mental health challenges faced by marginalised communities to systemic discrimination.[7]

Non-Affirming Therapy Practices and Their Influence

Most participants had experienced some therapy practices which they considered non-affirming. Several had experienced therapy that was harmful, leading them to discontinue sessions. Actively harmful therapy experiences included being accused of lying on therapeutic assessments. This would be universally considered malpractice or misuse of power, but these are especially likely to be harmful to neurodivergent people, who may be used to camouflaging their feelings and needs and are highly sensitive to rejection.[8]

Almost all participants also reported unhelpful experiences with therapists who gave excessive directives and advised them in non-collaborative ways, such as misdiagnosing, directing the client to take medication, and being dismissive of the client's neurodivergent identity without discussing it. This reduced trust in the therapist and infringed on the client's autonomy. This is reflective of research on neurodivergent people being weary of unfair hierarchies in relationships.[9]

Other practices participants considered non-affirming included being judged for 'not trying hard enough' to work on their mental health. Participants felt they were being held to ableist neurotypical standards, which created further shame for them. Women participants spoke of therapists victim blaming them when they were in abusive relationships, highlighting the need for an intersectional therapeutic approach.[10]

Significantly, several participants reported therapists not noticing their neurodivergent traits. Often, clients had done their own research and brought up their neurodivergence with therapists or had visited many professionals before being told they might be neurodivergent. This may be because neurodivergence presents differently in gender and other minorities, unlike how it is described clinically.[11]

Some of the participants still used language from the biomedical model to describe themselves, such as 'comorbidity', 'symptom', 'suffers from ADHD', and 'dysfunction'. This led us to question whether their therapists were unintentionally reproducing the idea of neurodivergence as a deficit without deconstructing the pathology paradigm with them.

Neurodiversity-Affirming Practices and Their Influence

While non-affirming practices made participants hesitant about seeking therapy again, some considerations that helped mitigate apprehensions about therapy included being able to find a therapist with similar values and beliefs, identities – queer, neurodivergent, polyamorous, etc., – and, in some cases, opinions on macro issues of the world. Identity-based matching can allow the clients' identities to be safely integrated in therapy with increased hopes of identity- and oppression-related competence in the therapist,[12] thus facilitating a sense of understanding and rapport.

Participants also spoke about intentional practices that made for an affirming experience. One example was the therapist validating the client's struggles with neurodivergence and acknowledging certain actions and emotions as 'normal' – such

'symptom'

'comorbidity',

The neurodiversity movement challenges this pathologising discourse by advocating for the recognition and acceptance of diverse identities as part of natural human variation and by standing for the rights of all.

'dysfunction'

'suffers from ADHD'

as touching one's face while talking to self-regulate, moving during the sessions, being overwhelmed by something that does not usually overwhelm neurotypicals – experiences now accepted as part of neurodivergent culture.[13] This made participants feel understood, compassionate towards themselves, and liberated from self-blame as they experienced a dismantling of neuronormative expectations. They also felt that their neurodivergence was appreciated, improving their confidence and helping them ask for accommodations in their relationships. Another significant finding was how much participants valued their autonomy in the therapy space. Therapists checking with clients about activities comfortable for them, collaboratively setting goals, letting clients steer the conversation, etc., place the locus of control back with the client. In a world that actively thwarts their agency and increases their internalised ableism, infantilisation, and helplessness, such practices can make them feel more in charge of their own lives as it places the therapist and the client on a more equal footing.[14] Other affirming practices included therapists making the experience more accessible for clients, by removing a noisy clock, closing the windows, turning down the lights, or providing session reminders. This helped clients build a 'second skin', which acted as an added layer of safety and comfort within the session.[15]

Participants also spoke about therapists' attentiveness in observing and understanding them, which allowed them to discover their neurodivergent identity and gave them the language and framework to understand their actions as opposed to seeing themselves as 'evil' or 'a bad person'.

Summing Up

Neurodivergent people experience additional mental health challenges due to systemic ableism. Conventional therapeutic methods and boundaries may not be helpful for them, instead needing therapists to be well informed on neurodivergence and be flexible in their approach. Given the higher probability of abuse faced by some neurodivergent identities,[16] coupled with their need for autonomy, therapists may be required to pay close attention to issues of power and social justice within the therapy space. This is in line with existing recommendations on transforming mental health systems globally, which state that it is important to embrace a rights-based approach and centre people's lived experiences.[17]

We found that while neurodivergent people struggle to find an affirming therapist, when they do, they recover from crises, experience more confidence, and ask for accommodations in relationships. It helps them understand, acknowledge, and appreciate their neurodivergence.

Farah Maneckshaw
is a therapist, researcher, and co-founder of The Mirrored Room, a queer-led mental health initiative, where she works with queer and neurodivergent individuals and couples. Her research interests lie at the intersections of mental health, gender and sexuality, and disability. She also writes articles in the media on mental health from a sociopolitical lens.

Amishaa Gupta
is a therapist, researcher, and co-founder of Parts of Us Psychotherapy. In therapy, she uses an eclectic approach, informed by psychodynamic, relational, narrative, and trauma-informed approaches. She has worked as part of different NGOs in the past and is driven towards doing community work. Her research interests lie at the intersections of gender, disability, caste, and class.

How

CONTEXT

How is the GMH field complicit in upholding colonial, racialized, casteist and Eurocentric power dynamics?

How does the GMH field treat identities of race, caste, nationality, ethnicity, religion, gender, ability, occupation and class across countries?

How does the Global Mental Health (GMH) field engage with mental health issues related to global humanitarian crises?

How does the GMH field engage with mental health distress in conflict zones, and does it decry the systemic forces that cause this distress?

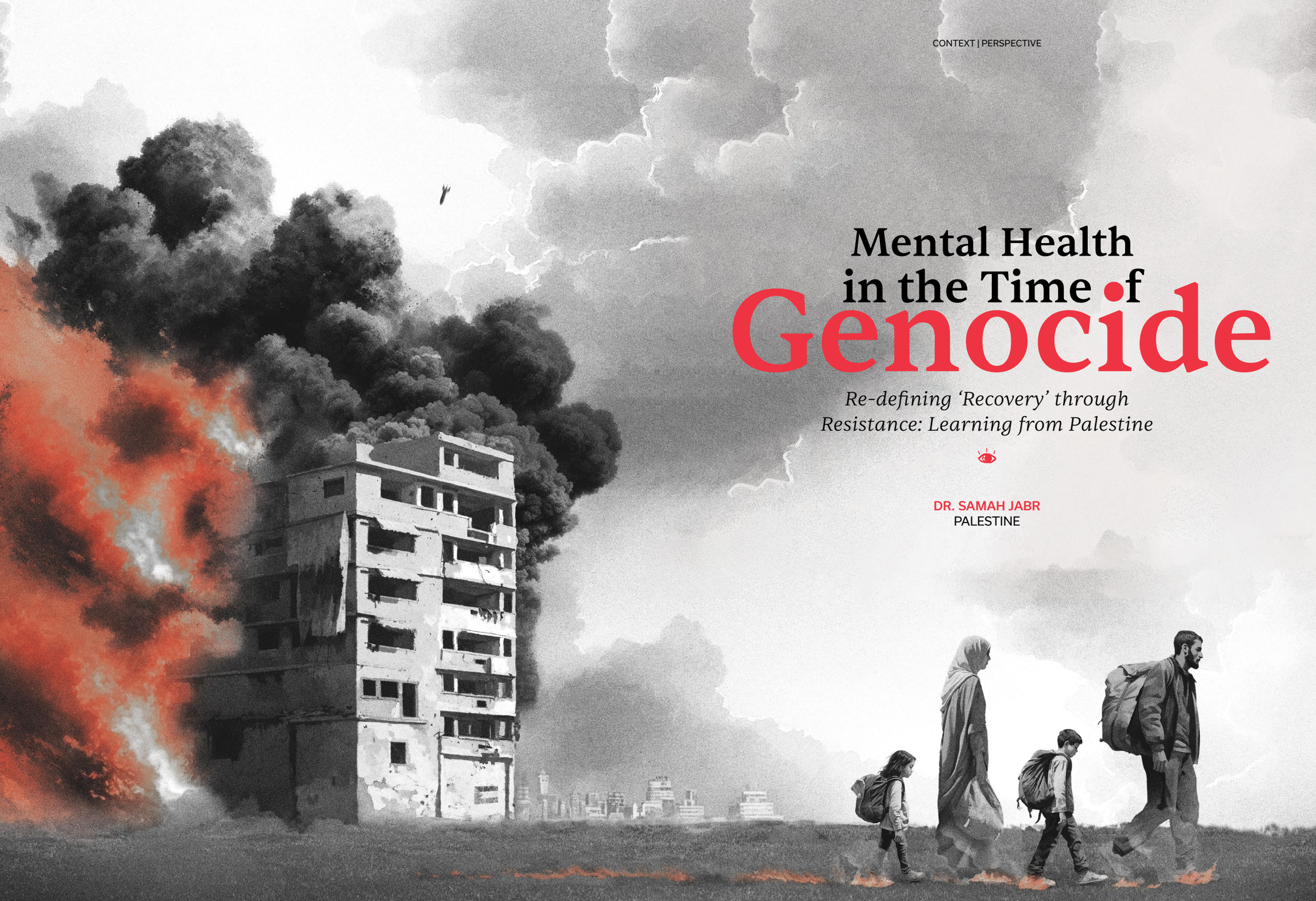
How has lived experience within the GMH field been defined, and does it fit LMIC contexts?

ADVOCACY
PERSPECTIVE
RESEARCH

Mental Health in the Time of Genocide

Re-defining 'Recovery' through Resistance: Learning from Palestine

DR. SAMAH JABR
PALESTINE



Mental health no more occupies a marginalised position within global discourses, in international policy making, and in inquiries around development.[1] Global mental health is a forum whereby new narratives of mental health are forged. Intended to be inclusive and incorporative of the 'Global South' voices, experiences, and audiences, it attempts to reimagine mental health by constructing an equalised platform that invites participation of marginalised perspectives on mental health.[2] But the nature of conversations around it and the political assumptions and implications behind them are in need of further critical examination.

This article is one such analysis of global mental health by narrating the mental health needs of Palestinian people, with the explicit political position the land and its people have been relegated to for decades. In such a narration, what becomes visible is the incongruence between the global mental health movement – specifically its silence on colonial structures – and the actual ground realities of 'non-Western' societies. It is these lacunae within global mental health that this article engages with.

The assault on Gaza has left an entire population suffering from trauma and loss.[3] The scale of persons affected makes individual psychological work impractical, especially given the absence of safety and the lack of what is necessary to meet basic needs.[4]

Lessons from Palestine

The psychological wounds and bereavement resulting from violence, annihilation, and forced displacement will continue to be felt. These realities force us to consider other therapeutic approaches – ones that can repair human connections and link individual lives to historical memory. The domain of lost rituals, of lingering grief, and of missing social networks, beliefs, and trust are collective rather than individual issues and cannot be reconstructed within clinics. These can be better addressed in public spaces instead of private ones, in places where people can recognise and share that their suffering has common roots. Since the psychological reckonings ahead of us far exceed the capacities of individual clinical encounters, we must adopt a new collective mental health practice.

Mental health in the Palestinian context is not merely a clinical matter but the sum of intersecting historical, social, and political dimensions. Lessons derived from liberation psychology[5] and community mental health[6] shed light on the multifaceted nature of mental well-being and recognise justice, human rights, and resilience as fundamental components. Understanding this is crucial in redefining mental health practices in Palestine.

Reassessing Our Mental Health Practice

The conventional biomedical approach to mental health often sidelines sociopolitical influences, focusing primarily on individual symptoms.[7] Social dimension is usually understood as the relevant support systems, relationships, socioeconomic status, and cultural norms that impact an individual's psychological well-being and mental health conditions.

The Palestinian experience emphasises the significance of the biopsychosocial model and adds an additional dimension: power dynamics as manifest in the lack of justice and the violation of human rights. Critically, global mental health remains silent on the colonial relations that continue to shape the social, economic, and political opportunities of different peoples.[8] Palestinian 'distress' does not exist in the vacuum, unattached to structures of Zionism and apartheid. It demands that the global mental health discourse extend to inquiries on such power dynamics. In this context, the process of reframing the concept of mental health must integrate the impact of Zionist political oppression, displacement, and violence on an individual's psychological well-being and on the well-being of the community itself.

Emphasising justice as the core of the social element in the biopsychosocial model ensures a holistic approach, accounting for collective trauma and enabling societal healing. The struggle for justice is not merely a political aspiration but also an essential element in individual and collective mental recovery. Addressing historical injustices, reclaiming rights, and advocating for freedom are inherent components of mental health restoration. Acknowledging the role of justice in mental recovery, then, leads us to encourage activism and social change as vital components of mental healthcare provision in Palestine. At the level of concrete interventions for the present, health professionals must be advocates for ceasefire and boldly challenge institutions that are silent or complicit in genocide. Mental health professionals contribute to the psychological documentation of the victims of torture.

Against Individualism

Palestinian mental health professionals must question the hegemony of a Western mental health practice in Palestine that emphasises positivism, individualism, ahistoricism, hedonism, and a homeostatic approach. [9] These values cannot explain many important features of the Palestinian experience. For example, the Israelis offer financial rewards to tempt Palestinians to inform on prisoners and resistance groups,[10] but in vain. A Western mental health model does not acknowledge that Palestinian resistance to the occupation is a healthy assertion of personal dignity and that international solidarity is itself therapeutic. Similarly, the notion of 'self-care' is often judged by Palestinians to be inappropriately self-centred given the context of genocide.

Foreign therapeutic frameworks fail to recognise both the unique challenges and the special coping mechanisms that characterise our community. Instead, identifying more culturally relevant approaches can offer opportunities for communal healing. Among these are community-centred initiatives; acts of recognition, remembrance, and mass cooperation; and creating support networks. Encouraging storytelling, solidarity, and safe environments can foster unity and resilience among individuals dealing with adversity. Modalities that incorporate collective prayer, street demonstrations, social networking, and public mobilisation represent healing practices and community-based interventions rooted in Palestinian contexts. The retrieval of memory is both therapeutic and an act of resistance, undermining the cynical hope expressed by Israelis that 'the old will die and the young will forget'.[11]

A MAN PRAYING IN GAZA

Faith and National Values as Anchors for Recovery

The Palestinian experience demonstrates the significance of faith and national values in bolstering resilience and recovery. Mental health professionals must be guided by the people who need our support and sensitivity to their cherished concepts. We need to understand what people mean when they say, 'We belong to Allah and to Him we shall return.' Through this, the bereaved

overcome the suffering of loss and the pain of separation from the deceased. It establishes the hope that the beloved is in a better place and that they will reunite one day. Just as we emerge from the same origin, we will in the end meet at the same destination. Such a statement, for the believers, can be more effective than techniques like eye movement desensitising and reprocessing (EMDR), or somatic experiencing, or trauma-focused cognitive behavioural therapy (CBT).

A CHILD AMONG WAR RUINS IN GAZA

Religious concepts like yaqeen (assuredness and certainty) or tarahum (compassion), national notions like sumud (steadfastness), and the politicised religious notion of ribat (protection of religious places) are important elements in understanding the Palestinian mindset as it responds to the horrific political reality.

Incorporating cultural rituals, such as the funerals of martyrs, can be profoundly therapeutic. These methods that recognise the struggle to liberate prisoners and celebrate their freedom as well as integrate traditional healing practices and cultural rituals validate cultural identity and shared heritage, offering avenues for emotional release and communal support.

Addressing Historical and Collective Trauma

While shared traumas must be reprocessed collectively, interventions aimed at healing historical and collective trauma within the Palestinian community require a nuanced approach. First, documentation and witnessing play pivotal roles in acknowledging and validating shared experiences. It is vital to create a safe space for individuals to express and process their trauma collectively. Community-based approaches, such as group therapy or support networks, dialogue, and public talks offer opportunities for shared healing. Emphasising collective resilience and providing platforms for storytelling and solidarity can foster a sense of unity and strength amidst adversity and protect against emotional fatigue among activists. Following the Jenin Massacre in 2002, the bereaved youth of Jenin guided by the German artist Thomas Kilpper built a sculpture of a horse from the debris of wrecked ambulances and cars destroyed during the military attack. The Jenin Battle Horse was erected at the roundabout near the survivors' camp and told the story of the massacre and the heroes lost in that battle. It became a symbol for rebuilding. Unfortunately, in the recent genocide in Gaza, the Israeli Army destroyed and confiscated the Jenin Battle Horse.[12]

Task-sharing among people in the helping professions is another response to the magnitude of injury in Palestine. Mental health should not be left to the few specialised psychiatrists and clinical psychologists alone. We have been training general doctors, nurses, teachers, and school counsellors to respond to the immense needs. Trauma-informed care in health and educational systems and trauma-informed parenting are also key avenues of response. Religious figures, if trained on mental health, can also play a pivotal role in community healing.

In Palestine, the pursuit of truth and justice is not solely a professional or political endeavour but an intrinsic aspect of individual and collective mental recovery.

Truth is another victim of political violence and to be able to seek and share our truth is affirming and empowering. It is important, too, to recognise that collective trauma is amplified by spreading misinformation and propaganda that denigrates Palestinians and injures their reputation.[13] Documenting and bearing witness to shared experiences create spaces for truth seeking, acknowledgment, and validation. Truth-tellers should be supported and celebrated. More than one hundred journalists were killed during the attack on Gaza.[14] Despite the danger, Al Jazeera correspondent Wael al-Dahdouh, who lost immediate family members and was then injured, continued to broadcast the truth about Gaza,[15] and Palestinians admire his courage. Palestinian journalists and medical staff need to be provided with psychological support to help them deal with stress and trauma consequences, burnout, and emotional fatigue.

The preservation of the Palestinian narrative and cultural identity, its resistance against oppression, erasure and denial, and the collective struggle for freedom foster a sense of agency and empowerment within the community. By encouraging active participation in collective movements and advocating for justice, individuals can reaffirm their role in the restoration of mental health and community well-being.

Conclusion

The margins, from where the Palestinian experience speaks, question the dominant modalities of mental health work that are biomedical and individualist, thus putting their utility in crisis. As global mental health continues to uphold Eurocentric models, it fails to imagine the relationships between mental health work and the necessary fight against colonial power.

The lessons learned from Palestine's poignant context offer profound insights and a transformative approach for mental health professionals worldwide.

Within every story of trauma lies the potential for resilience, recovery, and hope.

These dark times in Palestine require tireless dedication, innovation, and commitment to culturally sensitive and trauma-informed care. Our mental health professionals must navigate an intricate web of trauma, resilience, and healing. Their practice is a testament to the remarkable strength and fortitude exhibited by individuals and communities enduring protracted violence.

Dr. Samah Jabr
is an experienced Palestinian psychiatrist, psychotherapist, human rights activist, and writer. She is the head of the Mental Health Unit at the Palestinian Ministry of Health. She is skilled in cognitive behavioural therapy, mindfulness, clinical research, and clinical supervision. She has authored the book Derrière les Fronts-Chroniques D'une Psychiatre Psychothérapeute Palestinienne Sous Occupation.

Reshaping Narratives: Reproductive Justice among Women in Kashmir

Lived Realities and Ways Forward

MUJATABA NOORUL HUSSIAN & MAHNAZ AJAZ
Kashmir

Globally, women's reproductive health is a major determiner of their mental health. A study reviewed 219 pregnancy-related deaths among 9,894 women in 3 rural areas of Haryana state in 1992 and found that 20% were due to postpartum suicide.[1] Generally among women, suicide or parasuicide (thoughts of self-harm) is up to 20 times more common during or after pregnancy.[2] The case for understanding this often-ignored correlation between women's reproductive health and mental health is even stronger in conflict regions. Though the discourse around global mental health has evolved and expanded, mental health distress caused by living in conflict regions, especially in South and Southeast Asian countries, is not often discussed in mainstream global mental health discourse in a nuanced manner. If it is, voices of individuals affected are rarely considered.

PREVALENCE OF DEPRESSION IN KASHMIR

6.8% MEN

93.10% WOMEN

This paper, which presents the findings of a study conducted in 2022–2023 in a maternity hospital in Srinagar, the capital city of the Indian-administered union territory of Jammu and Kashmir, seeks to take a small step towards bridging this gap, with a focus on the Kashmir division (administrative) of the union territory.

Kashmir's Context and the Framework of Reproductive Justice

In Kashmir's complex political and social landscape, women face unique challenges related to reproductive justice.

The laws of Kashmir are imbued with patriarchal norms; laws related to women's rights face challenges of enforcement; and progressive legal reformation faces resistance from the community.[3] This affects women's reproductive autonomy. The prolonged conflict in Kashmir has further impacted this. In conflict zones, women face barriers to accessing reproductive and other healthcare. This has led to physical and mental health concerns. This is further exacerbated by the constant fear and insecurity of living in a conflict zone.[4] Many surveys indicate that Kashmiri women bear the burden of conflict in various forms, including stress, trauma, depression, spontaneous abortions, miscarriages, and the difficulties faced by 'half-widows' in their day-to-day lives.[5] In Kashmir's rural areas, the prevalence of depression among females is higher (93.10%) as compared to males (6.8%).[6]

It is crucial to explore and understand these challenges within the framework of reproductive justice, which encompasses the right to have an abortion and use birth control, to have children under chosen conditions, and to parent in safe and violence-free environments. Reproductive justice also propounds that a woman's capacity to decide her conceptive fate is also connected to the conditions in her locale and is not an issue of her choice and access alone. Instead of focusing on the means – debates on abortion and birth control that neglect the real-life experiences of women – reproductive justice focuses on the ends: better lives for women, healthier families, and sustainable communities.[7]

Lived Realities of Women in Kashmir

We conducted a study in the government maternity hospital in Srinagar, as it received patients from all over Kashmir. Initially, it was difficult to identify survivors of reproductive violence, but with the help of resource people, 10 women were identified. Names have been changed to protect the women's identity.

Case Study: Faika, in her 40s, had a chronic health condition that could pose significant risks during pregnancy. However, because of familial pressures, she was coerced into getting pregnant to give the child to her sister-in-law, who was childless. She faced emotional and physical toll in complying with the demands of her marital family. Faika's story showcases the intersection of familial expectations, societal norms, and the lack of agency over one's reproductive choices. At the time of this interview, she was pregnant and grappling with serious health concerns.

Case Study: Ayesha, in her mid-20s, was pursuing higher education when she was constantly reminded by her family of 'the importance' of marriage and motherhood. Soon after her wedding, pressure mounted on Ayesha to conceive, despite her explicit wish to delay pregnancy until after her exams. On her in-laws' insistence, Ayesha found herself pregnant within months of marriage, leaving her 'shattered and overwhelmed'. The stress of impending motherhood compounded the academic pressures, adversely affecting her mental health. She experienced anxiety, depression, and feelings of hopelessness as she grappled with the loss of control over her body and her future. The burden of societal expectations exacerbated her sense of isolation and despair. Despite seeking support from her maternal family, their adherence to traditional values only worsened her distress, leaving her feeling 'trapped and powerless'.

Case Study: Sara's parents forced her to have an abortion against her will, wishing to facilitate her divorce and relieve themselves of the perceived burden of a child. Sara, in her 30s, grappled with 'severe emotional distress and experienced feelings of betrayal, powerlessness, and profound grief' post her abortion.

The study revealed a lack of awareness among women regarding their reproductive rights and a deep-seated cultural stigma around openly discussing reproductive health. Many respondents conveyed having no choice over their reproductive well-being and feeling disempowered.

Illustration: Studio Ping Pong

Abrar Ahmad Guroo, a psychiatrist in the Kashmir valley, spoke to us of the undesirable outcomes of reproductive processes, especially when the women have no autonomy, such as the experience of lingering guilt, negative image of self and society, and negative emotions regarding reproduction itself.[8] These usually manifest as severe depression as well as adjustment issues. It would also make it difficult for these women to provide a safe, healthy, and loving environment for their children.

Further, Guroor said, women living in conflict zones face other significant challenges – like exposure to violence, insecurity, displacement, loss of loved ones, limited access to basic services and resources, and a constant state of fear and uncertainty – which contribute to a high prevalence of stress. They not only experience direct trauma but also witness and hear about the traumatic experiences of others in their communities. These factors put the women in a chronic state of stress and fear, which can have severe implications for their mental health. It can lead to the development of various mental disorders (as clinically defined), including anxiety disorders, depression, post-traumatic stress disorder, and adjustment disorders. It can also have physical manifestations such as headaches, sleep disturbances, and gastrointestinal problems and can disturb women's reproductive health, by leading to irregular menstrual cycles, hormonal imbalances, and increased risk of infertility. Stress can also result in decreased sexual desire and satisfaction.

The stories of coercion, lack of choice, and the impacts on mental health the women we interviewed experienced underscore the urgent need for holistic interventions.

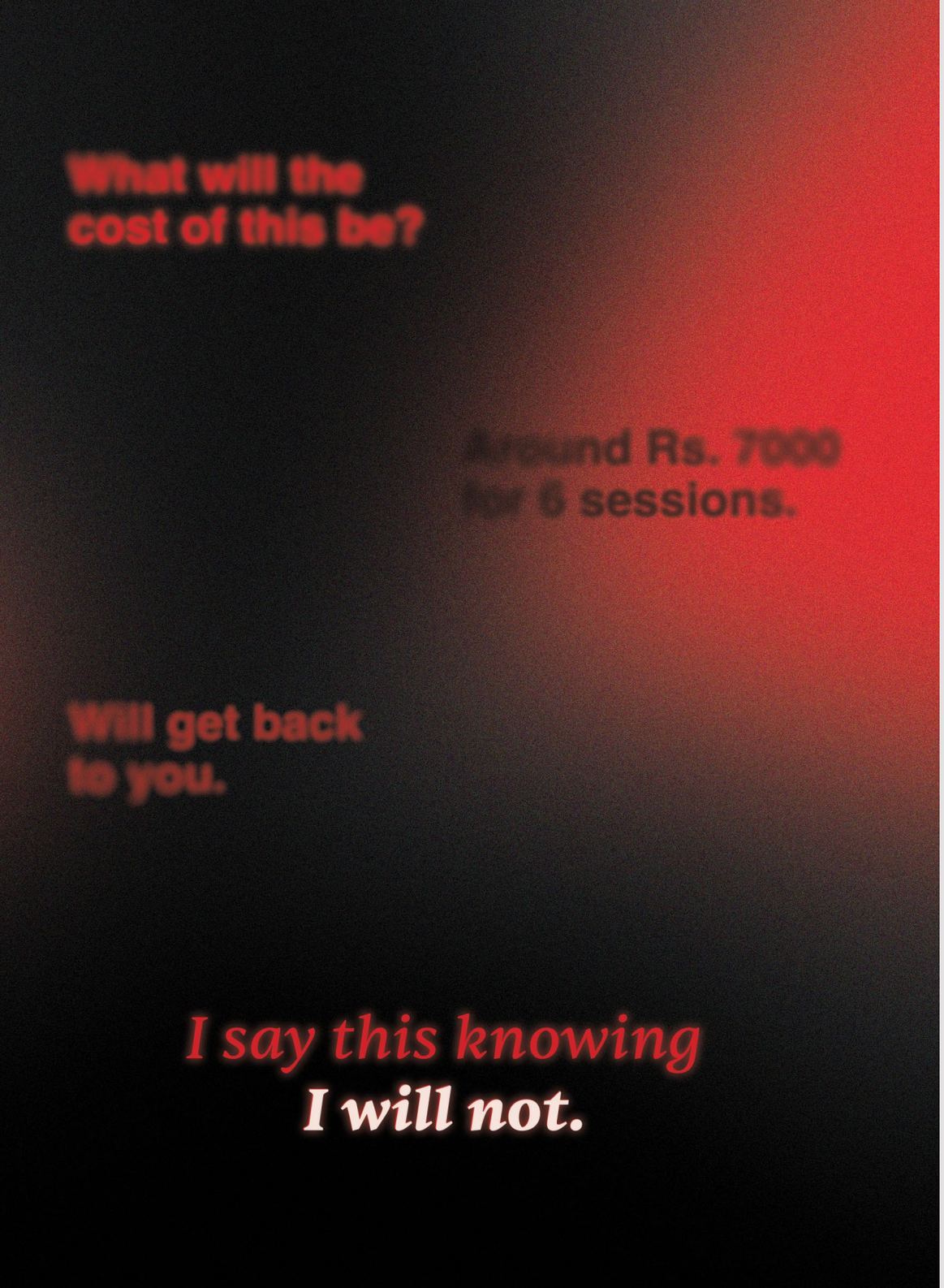
Addressing reproductive justice goes beyond policy changes; it necessitates fostering a culture of respect for women's autonomy over their bodies and choices, which has long been contentious and often overlooked in Kashmir.[9]

Deeply rooted in cultural norms, religious traditions, and the lingering effects of a prolonged conflict, the lack of choice Kashmiri women face in matters of reproduction is a multifaceted problem that demands urgent attention.

Alongside the recognition of reproductive rights and autonomy, we also suggest increasing funding for mental health services for adequate resources and staffing, expanding mental health services in underserved areas and communities, and implementing telehealth/teletherapy options to overcome barriers of transportation and geographical distance. Prioritising mental health support systems in Kashmir,[10] coupled with comprehensive education on reproductive rights, is imperative. Empowering Kashmiri women to navigate their reproductive journeys with autonomy and dignity, which is not merely a necessity but a fundamental human right, is essential.

Mujataba Noorul Hussian
is a research scholar at the School of Law, NIMS University, Jaipur, Rajasthan and has been working at the Institute of Mental Health and Neurosciences, Kashmir for the last five years.

Mahnaz Ajaz
is a research scholar at the School of Law, University of Kashmir.



Mental Health and Marginalisation A Personal Essay

RINKU

I start this article with the above encounter I had: a Dalit woman seeking mental healthcare in a Brahmin, capitalist patriarchy.

In a recent conversation with friends, we discussed marginalisation being both a major reason for poor mental health and a barrier to accessing healthcare. When I was a child, I had no friends and the girls of my colony used to ignore me. When I gathered the courage to talk to them, they took me to their home. It was the first time I had gone to somebody's house. They neither offered me water nor allowed me to sit on their sofa. Opening the almirah, they said, *'Yeh dekh, achhe kapde. Tera baap ye kharid nahin sakta, isliye tu hamari jaisi nahin hai. Nahi toh hamari dost ho sakti thi.* [See here, good clothes. Your father can't buy this, that's why you aren't like us. Otherwise, you could have been our friend.]' That day I knew they had closed the door of friendship on me.

I wonder how this has impacted my life and my decisions, be it cutting my hair to look 'pretty' like them, trying hard to become friends with the 'coolest people of the college', or enabling my own bullying by not raising my voice against it. There were 'light' jokes on a daily basis on my unclean school uniform which Maa used to handwash daily since I had only one pair. I never figured out what was 'unclean' about my clothes or what they meant by 'mazdoor wale per [labourer's feet]'. With time, I lost my confidence. Do all these incidents have nothing to do with my caste?

Manisha Mashaal, an anti-caste activist and founder of Swabhiman Society, a Haryana-based organisation of young Dalit women, talks about the links between mental health, educational institutions, and caste-based and sexual violence.[1] Although studies on global mental health have acknowledged student suicides in India as a serious matter, most

of them have not done a caste analysis.[2] In fact, the field of global mental health rarely considers caste as a major sociological factor impacting the physical and mental health of people from South Asian countries. Rob Whitley writes that mental health advocates avoid confronting 'uncomfortable truths' in developing countries such as the 'institutionalized inequality' of the Indian caste system.[3] This leads to a lack of nuance in the way 'experts' understand mental health in India. For instance, the lack of sufficient counsellors and low number of people seeking mental health services are frequently discussed as 'barriers' to mental well-being, but the bias that oppressor-caste counsellors have when engaging with service-users from marginalised caste backgrounds is often ignored, as are caste backgrounds of individuals who are able to access the required training to become registered counsellors.

I faced much caste-based discrimination in school, but my awareness back then was limited. On my first day of college, during a chat with some classmates, I misunderstood 'convent' as 'government'. Thinking I had finally met other *'government school ke bachhe* [government school students]', I jumped up excitedly, but was stopped and corrected. Instead, these private school students discussed in *angrezi basha* [English] big cars, luxurious clothes and bags, and bahar gaon ka tour [outstation trips]. I felt invisible. For months I had no courage, hope, or desire to go to college. The sudden urges to cry my heart out; being unable to breathe sometimes; people telling me, till today, *'Tere paas toh quota hai* [You've got quota]'; even my close ones acknowledging only the 'benefits' I got; questioning myself when people asked me to 'dress achhe se [nicely]' for events; the constant humiliations: I now know that these were not normal or okay and that I had real mental health concerns that were not acknowledged by the people around me. During my masters' course, I learnt about identities from an intersectional lens. It was also the first time I recognised the importance of self-identity and relooked at my life experiences through the lens of caste. My identity has always been with me, been the reason for things that happened to me, for things I got, for things I lost. Even if I was ignorant about my identity, society knew how to treat me.

With time I also understood that our bodies, which have their own politics, retain memories of struggles; for marginalised people and communities, our trauma is all over our bodies. Dalit trauma has been part of marginalised people's lives; we are forced to live in a 'perpetual survival mode' as Priyanka Singh writes.[4] Our intergenerational trauma starts with the 'first generation that is directly impacted by threatening circumstances and suffers post-traumatic stress, passed on to the future generations through secondary traumatisation, experienced in the form of emotional dysregulation, chronic anxiety and high stress levels, intra-community violence, unhealthy attachment styles, and higher levels of physical and mental illnesses'.

Even in the safest spaces and among the safest people, my body feels a shock when someone puts their hands on my shoulder or back suddenly.

Now, even with the awareness of my sociopolitical and economic location and despite my need for therapy, it is difficult to afford it. Moreover, though there are conversations around patriarchy, gender, intersectionality, etc., mental health is still not seen from an intersectional lens. People around me go for a movie or coffee or go shopping for self-care. They have the time to reflect on their mental health and well-being. I have felt sad, lonely, and hopeless, constantly feel unproductive and feel guilty. But I cannot afford to feel this way; I have the responsibility of my family. The ideas of self-care and well-being are capitalist, without taking into account affordability and sustainability, especially for marginalised people. Aatika Singh and Shubhkaramdeep Singh highlight how historically oppressed communities cannot afford to check on their mental health and well-being and even 'the most-educated and well-placed Dalits don't have access to health care and therapy that is rooted in our socio-political realities'.[5]

I hesitate to go for therapy and don't believe it can bring any change in my life. Divya Kandukuri, who runs Blue Dawn, a mental health support and facilitation group addressing intergenerational trauma of marginalised communities, questions, 'How many understand the intersection of caste and mental health?'[6] I think very few.

Mental health carries a lot of stigma; additionally, Dalit communities have been stigmatised by society for centuries. The overlaps between these two need attention and action. What stops me from seeking out therapy is cost, surnames, accessibility, and so on.

Looking back at my life I see these identities of mine – like when I used to get punished for not getting nutritious food to school but only namak ka paratha [salted paratha]. Its impact was never acknowledged as a lifelong trauma, which manifests in my not carrying home-packed food, feeling shame while chewing, and so on. The structure that affects my mental health is never taken into consideration. It reminds me of Rohith Vemula's last words –

'The value of a man was reduced to his immediate identity...'[7]

Society does not want to talk about this; mental health is a marginalised topic in marginalised communities.

The global mental health field must take these into consideration in order to advocate for mental health for people of marginalised castes. Recognising that the Dalit community has had a lot of intergenerational trauma, the current therapeutic facilities must speak to the needs of people who have been ignored for centuries. Moreover, seeking mental healthcare should not be a luxury but a right and should be affordable. We each have a right to a dignified, affirmative, and inclusive life.

Rinku
is Dalit-Dusadh feminist, artist, poet, and writer. Rinku has written articles about the struggles and challenges of Dalit people in urban set-up, which have been published in feminist and youth online platforms.

Warriors Within: Decoding the Paradox of Strength and Vulnerability among the Naga Tribe

The Listening Station Project

KHEKTO CHISHI Nagaland

The hills of Nagaland echo with tales of valour, resilience, and the indomitable spirit of its people. Deep-rooted cultural traditions tell stories of triumph over external challenges, fostering an ethos that celebrates physical and emotional toughness. Yet, this very cultural resilience inadvertently contributes to a stigma around vulnerability and mental health.

As the founder of the Listening Station – a mental health outreach project in Nagaland that runs a helpline and a partner of Mariwala Health Initiative – the author of this essay has had the opportunity to examine this paradox at the core of the Naga identity from up close. This article seeks to explore the cultural underpinnings that shape the Naga psyche, so as to better understand the factors that affect their mental well-being.

Cultural Resilience, Mental Health, and the Fear of Societal Judgement

Nagaland's cultural resilience, forged through centuries of warrior traditions and by navigating historical struggles, has inadvertently established emotional vulnerability as a deviation from the expected norms. This has fostered an environment in which mental health concerns are dismissed or concealed. The fear of societal judgement is a formidable barrier to openly discussing mental health.

Individuals perceive seeking help for mental health challenges as a personal failure.

Consequently, many choose to suffer in silence rather than risk social alienation or be seen as weak. Breaking this cycle requires dismantling the stigma surrounding mental health and promoting a culture that encourages seeking help as a sign of strength.

Cultural Sensitivity in Global Mental Health

In the context of global mental health, integrating culturally sensitive mental health interventions and acknowledging both visible and invisible challenges in the community becomes particularly crucial in tribal contexts. India harbours one of the world's largest tribal populations, constituting 8.6% of the total population in the country with 705 tribal groups.[1] These communities face heightened vulnerability to mental health issues due to the impact of rapid social changes, lifestyle

alterations, shifts in beliefs, and the challenges of acculturation associated with urbanisation.[2] Despite various initiatives, including the formation of the Ministry of Tribal Affairs in 1999 and the National Commission for Scheduled Tribes in 2004 as well as the United Nations Declaration of Rights of Indigenous Population in 2007, there remains a dearth of evidence on mental health morbidity among tribal populations and their needs. The existing literature – such as the ICMR Bulletin (2003), the Report of the Technical Committee on Mental Health (2016), and the National Mental Health Survey (2016) – are inadequate in addressing mental health in tribal communities. Even the Report of the High-level Committee on the Socioeconomic, Educational and Health Status of Tribal Communities in India (2014) provides limited information on tribal people's mental health.[3]

Limited research exists on the health of the constitutionally recognised Scheduled Tribe (ST) populations in India, particularly in the domain of mental health, which is already a neglected sub-area within healthcare services. The dearth of data on mental health challenges among tribal communities globally contributes to a poor understanding of their mental well-being. Despite the available data indicating worsening health indicators and reduced access to health facilities among tribal communities, the specific burden of mental health challenges within this population remains poorly documented.[4] The traditional livelihood system of ST communities has experienced conflicts with forces of modernisation, resulting in the loss of customary rights over livelihood resources, subordination, and low self-esteem, contributing to significant psychological stress. These communities face challenges with poor health infrastructure and limited mental health resources, both notably worse compared to other communities in similar areas.[5]

In low- and middle-income countries (LMICs), only 15%–25% of individuals affected by mental health concerns receive any form of treatment, leading to a considerable 'treatment gap'. Rural populations, particularly ST communities in India, encounter more substantial treatment gaps due to inadequate infrastructure and resources for healthcare delivery, with minimal capacity for providing mental healthcare.[6]

Efforts to integrate culturally sensitive mental health interventions for tribal people involve tailoring psychological support and therapies to align with the unique cultural nuances and beliefs of these communities. This requires a comprehensive understanding of their historical and social contexts.

Historical trauma, displacement, and the impact of colonial histories can contribute to the complexity of mental health challenges among tribal populations.

The acknowledgement of these factors is crucial in designing interventions that go beyond surface-level symptoms and address the deeper roots of their mental health concerns.

The Sociopolitical Landscape: Complexity in the Nagas' Collective Identity

The Naga identity unfolds as a dynamic interplay between individual, community, and national dimensions.

Central to the understanding of the Naga people's dual nature of strength and vulnerability is their enduring struggle for autonomy and acknowledgement. The clash between preserving individual identity, maintaining community cohesion, and navigating the demands of national integration creates a nuanced array of challenges. This collision between the historical quest for autonomy – deeply rooted in anti-colonial resistance – and individuals' personal struggles forms a complex backdrop to the broader narrative.

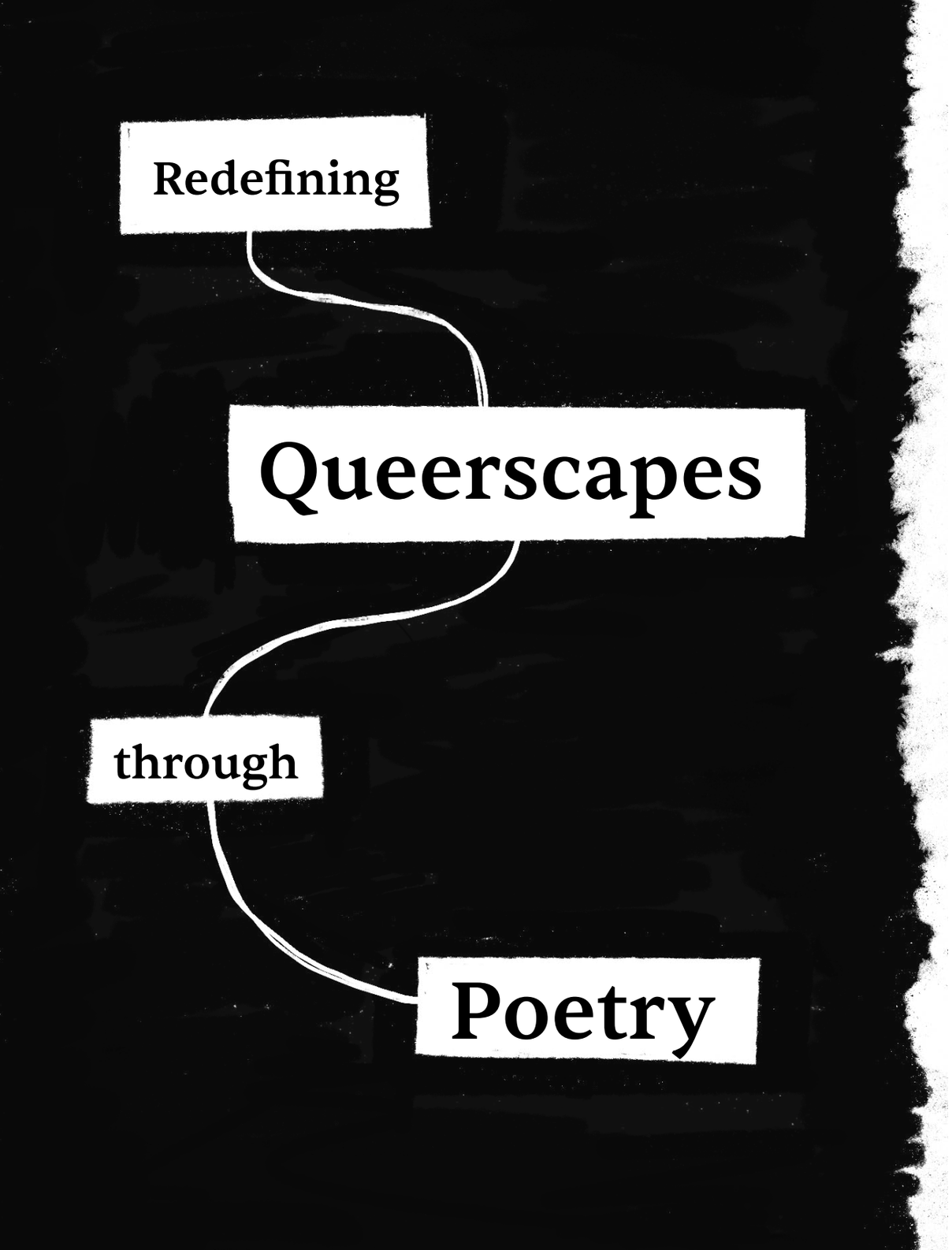
At the individual level, a Naga person grapples with the intricacies of personal identity against societal expectations and political dynamics. The historical struggle for recognition further amplifies this individual struggle. At a collective level, the delicate balance between affirming a distinct cultural identity and aligning with broader national frameworks mirrors the complex dance between toughness and vulnerability. Moreover, the preservation of cultural heritage is intricately woven into the collective identity of the tribe, not only serving as a source of strength but also contributing to vulnerabilities when external pressures and modernisation come into play.

Connecting the Threads: From Cultural Resilience to Mental Well-Being

The ongoing efforts to intertwine cultural elements with mental well-being in Nagaland are not standalone endeavours but are integral parts of a collective journey. Through community engagement, educational initiatives, storytelling, and tailored counselling, Nagaland has the potential to reshape its narrative – one that recognises strength in vulnerability, resilience in emotional well-being, and unity in diversity. In this transformative journey, the Listening Station and similar projects provide hope. In its commitment to providing a platform for sharing mental health concerns, the Listening Station is a catalyst for dismantling the stigma associated with mental health. By actively engaging with the community, it reinforces the idea that each individual's journey is distinctive, valid, and worthy of acknowledgement. Similar initiatives, like the Serendip Guardians and District Mental Health Programmes, align with this ethos, collectively contributing to reshaping societal perspectives on mental well-being in Nagaland.

These initiatives embody the belief that the collective strength of a community lies in its ability to embrace and support the diverse narratives within it to create a more inclusive society. In doing so, they foster a community where openness about mental health is not only accepted but also celebrated as an integral part of the cultural fabric of Nagaland. The integration of mental health initiatives with cultural sensitivity is not a departure from tradition but an evolution – one that enriches the cultural narrative with resilience, understanding, and compassion. It is a testament to the strength derived from not only external battles but also the courage to confront and support the internal battles within each Naga individual.

Khekto Chishi
is the founder of the Listening Station, Nagaland. Concurrently, Chishi is immersed in doctoral studies, concentrating on an in-depth exploration of the prevalent ¸mental health concerns of young individuals grappling with addiction to sunflower (crude heroin) and its effect on mental health in the Northeast region of India.



Drawing Attention to Art-Based Community Healing Approaches and Chronicling Housing, Healthcare, and Workplace Violations of Queer-Trans Communities in India

RAJU BEHARA
Bengaluru

The Absence of Queer Contexts in Global Health

Global health's frequent overlooking of queer people's experience is particularly striking given its vision of 'including the excluded' and the significant intersection of transnational health issues with LGBTQI+ populations. These communities face disproportionate health issues, including higher rates of communicable and non-communicable diseases, compared to cisgender, heterosexual individuals. Moreover, health outcomes within LGBTQI+ populations vary substantially; yet they are often grouped together indiscriminately in analyses.[1]

Many projects spearheaded by the queer community seek to address this gap, particularly in global mental health. They use poetry and art in community spaces and expressive arts psychotherapy (EAP) in queering and decolonising safe spaces, among others. But EAP projects are also often critiqued for not addressing the socio-legal origins of marginalisations and the ramifications of restricted access to advocacy and legal support. Addressing these structural issues through art has been explored by many marginalised communities. Conducting EAP through a socio-legal lens would lend unique perspectives to decolonise global mental health.

This paper presents one such initiative. The Queer Judgments Project (QJP) challenges the articulations in legal judgments regarding sexual orientation, gender identity, gender expression, and sex characteristics (SOGIESC). Its primary aim is to re-envision, rewrite, and reinterpret judgments addressing SOGIESC issues from queer and complementary perspectives globally.[2]

Art-Based Community Healing

My work with QJP focuses on the Section 377 litigation, through which the colonial-era law that criminalised same-sex relationships was struck down in 2018. I document the missing social histories of LGBTQI+ communities – such as housing, workplace, and healthcare violations – from the litigation and examine the impact of legal decisions on the mental health of LGBTQI+ individuals and movements. The strand of the QJP project I focus on, Redefining Queerscapes, portrays these stories through art forms that are easily disseminated. One dimension of it is pilot poetry workshops at queer-trans spaces across India. These workshops, which started in 2019, explore poetry and art to address discrimination in workplace, healthcare, and housing, aiming to rewrite the concept of safe spaces. Inspired by projects like the Scottish Feminist Judgments Project (SFJP) and Danish Sheikh's Love and Reparation, our Queerscapes work draws on regional folk art and encourages workshop participants to reinterpret law through blackout or erasure poetry. Participants black out portions of a written/typed text to create poetry with the remaining words, providing a visual representation of the Section 377 litigation

from the subjects' perspective, following Linda Mulcahy's approach.[3]

Redefining Queerscapes also included an ethnographic study through interviews and workshops in Andhra Pradesh and Karnataka to document overlooked social histories of workplace and healthcare harassment. This revealed prevalent issues in trans and non-binary healthcare experiences, including the invisibilisation of their journeys, consistent misgendering, and inappropriate assignments to gender-mismatched wards. Respondents expressed that healthcare settings often led to a profound detachment from their gender identity. When the findings are observed in correlation with data presented from the TransCare project[4] – a collaborative effort hosted at NGO Sangath – it can be noted that many Indian medical practitioners still lack meaningful connections with the queer-trans communities they aim to serve.

Challenging Epistemic Norms: Addressing Hetero-Cis-Normativity

When presented with different texts on violence in healthcare, participants engaged with ideas of empowering themselves and scripted ideal 'safe' healthcare experiences, which have been systemically denied. These experiences echoed broader struggles within global health, which often operate from an epistemic position of hetero-cis-normativity.

Mental Health [redacted] Department give it to me till I get [redacted] my [redacted] physical [redacted] transition.

The courage [redacted] and [redacted] conviction it takes [redacted] to [redacted] assert yourself is [redacted] Healthcare [redacted]

In this blackout poem (Figure 1), addressed to the Mental Health Department, Abigail Silversmith asserts their lived experiences.

Figure 2. Blackout poem from Namma Pride Trans activist and healthcare practitioner Aqsa Shaikh has been highlighting the problematic quest for the 'normal body' in medical science, emphasising the exclusionary nature that hinders correct healthcare access for marginalised groups.[5] She challenges medical students to encounter cadavers of trans individuals or of those with disabilities.

During our poetry workshops in 2021, we examined first-hand narratives of what accessing gender-affirming healthcare meant. Participants often touched upon their definitions of freedom and what it meant to be free, considering their historical relationship with oppressive laws like Section 377 of the Indian Penal Code, 1860 and the Criminal Tribes Act, 1871[6]; the latter particularly targeted and ostracised Hijra communities from their birth. The poets shared that poems written under oppressive State regimes resonated closely with their exercises.

Mental Health as a Justice Issue

The criminalisation of queer-trans individuals over decades has limited their access to infrastructure, of all kinds, but especially of healthcare. Deepa Pawar of Anubhuti Trust points out the impact that access to rights can have on the mental health of a community and frames this as 'mental justice'.[7] According to Pawar, mental justice places emphasis on community healing and on enabling access to rights in a dignified, non-discriminatory manner.

The historical oppression of trans communities, initiated by the Criminal Tribes Act in 1871, involves economic, social, physical, and political exploitation, coupled with mental suppression to debilitate them over time. Oppression erodes communities' mental resilience and coerces them into accepting the discrimination and violence against them. Modern Indian trans communities, criminalised for dissent, have endured over 150 years of severe mental injustice, including forced migration, arbitrary arrests, and restricted access to essential services like HIV treatment.

Various mental healthcare models target these challenges, including collaborative care models, community-based approaches, and culturally sensitive interventions. Recognising historical traumas, adopting inclusive mental healthcare models, and embracing intergenerational wisdom are crucial for holistic well-being. Samah Jabr's question, 'What is sick, the context or the person?'[8] prompts reflection on the West-developed tools for mental health.

The World Health Organization (WHO) remains lacking in conviction in this regard. Their International Classification of Diseases listed being transgender as a mental disorder until 2019.[9] Only in 2013 did WHO produce its first ever report on the health of LGBTQI+ people,[10] but there are currently no studies funded by WHO on the intersection of caste, class, disability, and queerness. Within this vulnerable geopolitical context, the use of progressive, affirmative healthcare guidelines is a radical act of resistance against a colonial, archaic, and anti-LGBTQI+ agenda. We locate our work within these acts of decolonial resistance.

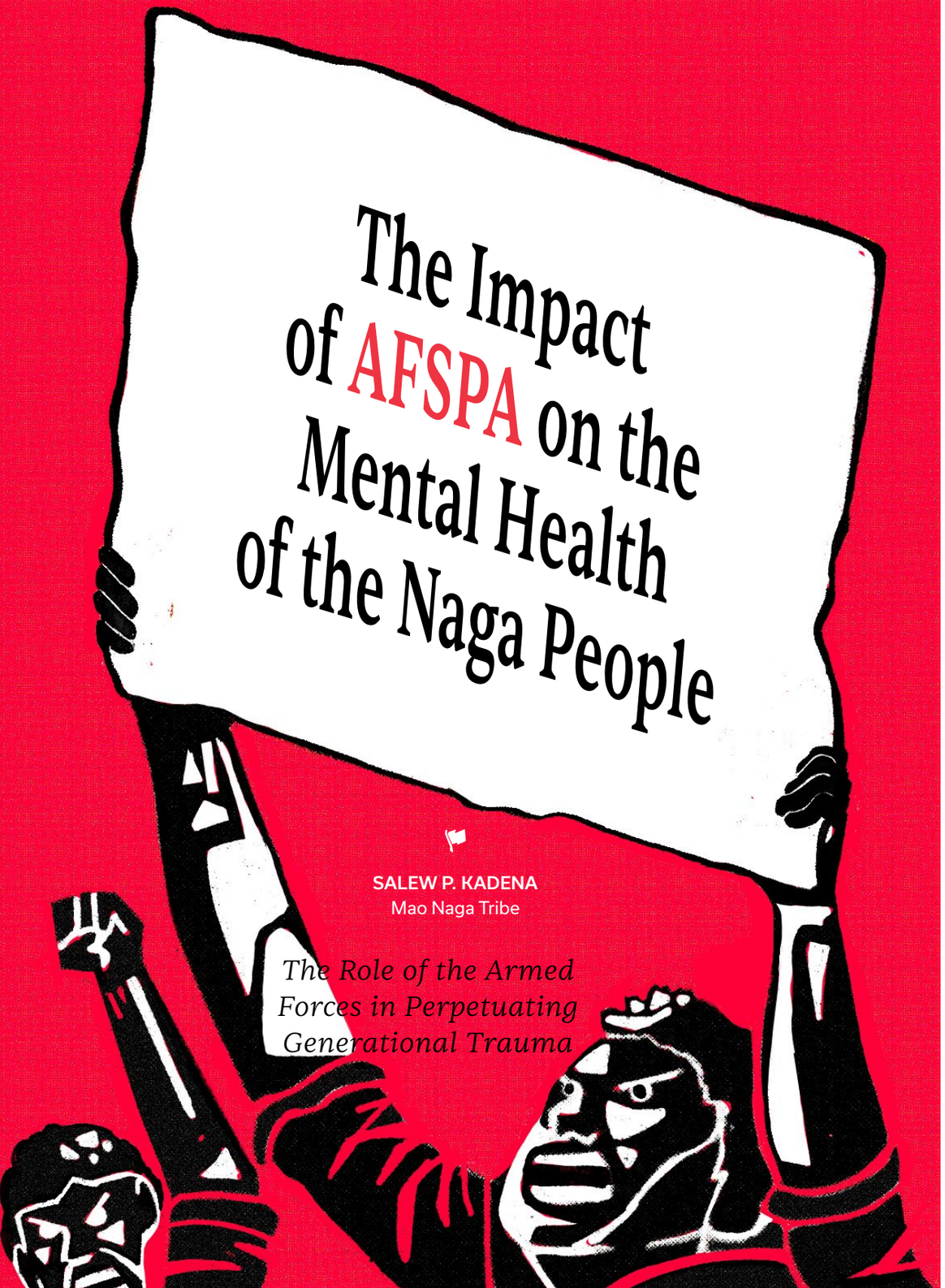
Reimagining Global Health

The Yogyakarta Principles, a document on human rights with respect to sexuality and gender, calls for competently trained healthcare providers for the proper application of international human rights laws addressing gender and sexuality.[11] Healthcare facilities around the world must strive to be the safe spaces that LGBTQI+ people desperately need. This endeavour will align with the third goal of the United Nations 2030 Agenda for Sustainable Development,[12] which is to ensure healthy lives and promote well-being for all at all ages. We need to reflect with urgency on how State actors, legislators, and policymakers propagate narrow views of the queer-trans community. It is important to observe how this vicarious violent viewing of queer-trans communities' ongoing wounds and trauma keeps perpetuating a Western worldview, thereby overlooking caste violence and able-bodied Savarna gaze.

We need to look at art-based therapy through a lens that defies our colonisers' rulebook. In the workshops, Queerscapes relied on Indian queer-trans artists and narratives. We encouraged participants to use Telugu, Urdu, Tamil, and Bengali to decolonise language and challenge colonially inherited laws and trauma.

It is important to chronicle movements, wounds, and healing not as individuals but as a collective queer community. As we remember Aarvey, Pranjal, and the queer-trans lives lost in the past few years, we need to look at introducing such frameworks in schools. Decolonisation of global health has to go beyond cosmetic changes and become a radical transformation, especially for those of us in the Global South.

Raju Behara (she/they)
is a peer support provider and an independent researcher, with a master's in Pharmacology and Health Policy. They work on evidence-based legal and policy research on mental health and directly engage with communities. Through Piravi Art Community, they have been advocating for a community-based model of mental healthcare using poetry, art, and storytelling.



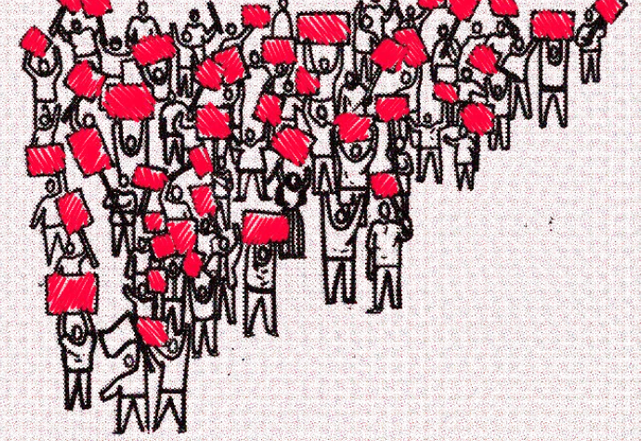
This article argues that the Armed Forces (Special Powers Act) (AFSPA), 1958,[1] a legalised offence, lies at the root of mental health distress and generational trauma in the Naga areas. The Naga people inhabit, along with other communities, the Northeastern states of Nagaland, Manipur, Arunachal Pradesh, and Assam, though the impact of AFSPA is felt in all the seven states of the region. The act covers the deployment of the Indian Armed Forces, the state forces, and paramilitary forces (henceforth collectively referred to as 'the armed forces') in areas classified as 'disturbed'. This refashioned colonial-era law passed by the erstwhile Jawaharlal Nehru government not only gives broad rights to the armed forces – including the right to use force and arrest people without a warrant – but also empowers them with unbridled access and immunity against any judicial scrutiny.

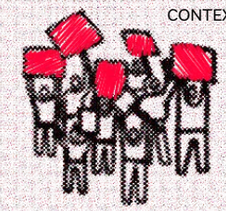
This act, which has been in effect in different parts of the Northeast by turns since its passing, has led to innumerable human rights violations including rape, extra-judicial murder, molestation, and torture.[2]

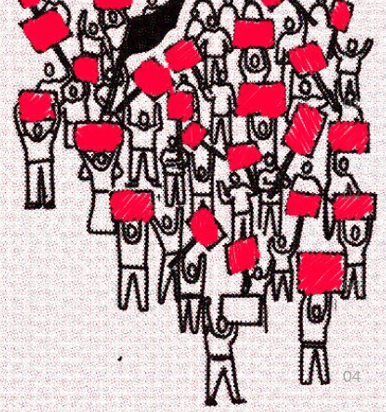
Numerous organisations and people have criticised the act and called for its repeal. But the law remains in place due to, it can be argued, the Centre's intransigence and the judiciary's reluctance,[3] the Centre's numbness to the periphery,[4] and more importantly, the system's violent aversion to Indigenous tribes,[5] who form the majority population of the Northeast areas under AFSPA.

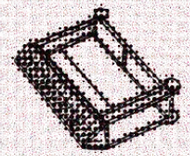
Apart from these physical cruelties, the Nagas also experience mental distress due to this draconian law, which is often overlooked. Physical ailments have always taken precedence over mental health in conflict areas. Also, in poverty-prone regions, the focus is on 'primary needs', which usually do not include mental health. Moreover, there is both non-availability of mental healthcare as well as poor access to whatever little resources might be available. This is evident from the fact that there is a lack of overall healthcare facilities in the region. A study by New Delhi–based think tank Development Intelligence Unit shows that 73% of people from the Northeast migrate to other regions for medical treatment.[6]

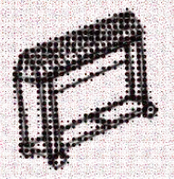
Even the most developed countries still flounder when it comes to mental health. In the United States, for instance, a massive 57% of the population is reported to suffer from difficulties related to mental health,[7] and even amongst those undertaking treatment, 31% are apprehensive of the stigma among their friends and family.[8] In low- and middle-income countries, the numbers are exceedingly low and up to 85% are untreated.[9] Moreover, according to the United Nations (UN), one in five individuals in conflict zones suffer from mental health concerns, considerably more than the global average.[10] The situation in Naga regions under the rule of AFSPA only proves this. The Oinam massacre,[11] the murder of Thangjam Manorama,[12] the Mokokchung massacre,[13] the Oting killings,[14] and the Phor village massacre[15] are only some of the recorded instances of the armed forces perpetrating excessive human rights violations on innocent civilians in Naga-inhabited areas. During the law's initial application in the 1950s,[16] covering the Naga areas of Manipur and Nagaland, there were multiple cases of human rights violations, most of which were not extensively documented, when entire villages were dislodged and granaries burned.[17] This agrarian society considers granaries to be 'sacred' and representative of the community's physical and mental nourishment. The enforcement of AFSPA is indicative of deliberate targeting of the psychological stability in the populace and perpetuating the cycle of trauma.











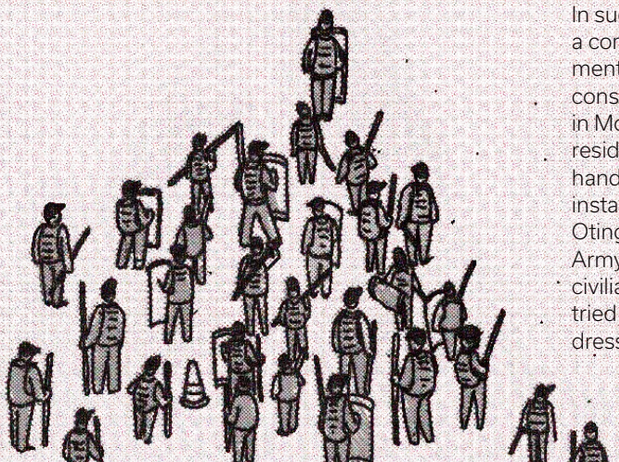
Mental health distress is prevalent especially among the older generation Nagas, who have borne the brunt of the violence in the region since AFSPA's inception.

These tales of displacement and horror, weaving together multiple generations, have also mushroomed into intergenerational trauma.[18]

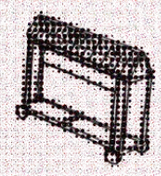
The enforcement of AFSPA lies at the very root of psychological tyranny over Nagas not only in the region but also those outside it; it has a cascading effect. Migrants from the Northeast are looked upon by people of the 'Mainland' as those from regions of perpetual strife. With prevalent binaries of 'Mainland India' and 'the Northeast', the latter has ended up becoming perceived as a hotbed of terrorism. This is also another stratagem to subvert reconciliation and normalise the perception of the region being a 'disturbed zone'. Such terms lead to the creation and continuation of stigma.

While there are some steps towards peace in the region and even a decline in recorded atrocities,[19] AFSPA is still operational in several parts of the Northeast and its repeal remains elusive, keeping the fear of the violence alive, especially for the older generation.

There is an urgent need for an official acknowledgment of war crimes on non-combatants and the nefarious deployment of AFSPA against innocent civilians in the region. This would lead to a semblance of 'closure' for the afflicted and to dialogue for peace and amnesty. However, establishing the atrocities of the armed forces is a slippery slope, and especially under the vestiges of AFSPA, it would most likely remain an unfulfilled hope. Moreover, in the construction and perpetuation of the idea of 'disturbed areas', there is a normalisation of the routine violence, which has trivialised all civilian atrocities and mental health trauma throughout the region and so is comfortably shielded from neutral, external evaluation. In such a situation, there is active denial, a complete whitewash of generational mental trauma. A clear example is the construction of an Assam Rifles memorial in Mokokchung district of Nagaland, whose residents had witnessed atrocities at the hands of the same contingent. Another instance is the assault on the memory of the Oting killings. In 2021, a unit of the Indian Army's Para Special Forces massacred civilians in Oting village of Nagaland and tried to pass them off as militants by dressing them up in military fatigues.[20]



As a response, a Black Day was solemnly observed in all the Naga areas and the Hornbill Festival, an annual cultural event organised by the Nagaland state government, had to be called off that year. However, in the 2023 edition of the Hornbill Festival, the Indian Army morung, or house, was featured, even with people strongly protesting against it.[21] Addressing intergenerational trauma is a very complex process, which involves engagement from several stakeholders, including multiple organs of the State as well as the affected people. The primary steps towards this would be renewing the trust and confidence of the local populace and rectifying past blunders through a sincere outreach attempt. One of the most crucial aspects of this would be setting up a strong mental health framework for the community. In recent times, the armed forces have initiated certain outreach programmes, such as organising football tournaments and medical camps.[22] Despite the bloody history, football has turned out to be a galvanising sport, an instrument of hope and a successful coping mechanism. But these are still band-aids, the fractures run deep. It is incumbent on the government of the day to earnestly endeavour for peace, reconciliation, and healing.



Salew P. Kadena
is a student at the Gujarat National Law University. He belongs to the indigenous Mao Naga tribe. He is a member of the Youth Advisory Board of Being Initiative engaged by CMHLP and Sangath. He was a YECAP (Indigenous Cohort) Fellow with UNDP Asia-Pacific. His interest lies in the intersection of Indigenous rights in mental health, internet and climate space.

Who

Who commissions research in the GMH field, and how much of academic publishing involves collaboration with local communities, survivors/service users?

How

How does the GMH field engage with the carceral system?

How does the GMH field address the health issues of communities marginalised by colonisation that reside within Western nations?

How does the GMH field position social and environmental factors such as poverty and food insecurity in the context of mental health issues?

Where

Where and how are recent digital solutions being put forth to address mental health concerns? What specific mental health conditions do these solutions address, and how effectively do they do so?

ENGAGE

SERVICE DELIVERY
RESEARCH
LAW & POLICY
ADVOCACY

Collective Healing and Trauma-Informed Approaches for the Mental Health of Survivors of Trafficking

Long-term effects of trauma, multiple victimisation, and our collective care approach for survivors of human trafficking as it pertains to long-term integration into society.

FAITH WANJIKU MWANGI & LINZY LIVIAN OTIENO
Kenya

Trauma-informed is a term that has been widely adopted by many organisations working directly with impacted communities.[1] Trauma-informedness means — understanding the impact, signs, and symptoms of trauma, integrating this knowledge into practices and procedures, and purposely preventing the causation of further harm (re-traumatisation).

Azadi is a survivor-led organisation whose goal is to create spaces and programmes that enhance the agency of survivors of trafficking, support recovery from trauma and sustain their reintegration into society. One of the values that govern all our operations is that "we are trauma-informed," which means that we make continuous efforts to learn and understand the effects of trauma experienced by survivor leaders, as well as the symptoms and presentation of trauma through a cultural lens. We try to ensure our well-being practices are founded on the principle of 'do no harm'. We do this by actively de-centering colonial styles of providing mental healthcare which often operates with a normalised degree of coercion, pathologising day-to-day human experiences[2] and perpetuating the idea that healing must happen in isolation[3].

Our trauma-informed approach is based on the understanding that each person in the Azadi community has experienced trauma in their lifetime. We recognise the signs of

trauma and ensure that mental health and well-being practices are incorporated into our organisational processes, procedures, practises, and programming. Our approach to recovery focuses on healing as a collective. We have incorporated activities and safe places that enable us to embark on a healing journey together while also building individual agency. We have realised that people rarely recover in isolation and have therefore seen the importance of healing within the community.

As a community, we endeavour to embrace community-centred trauma recovery practices because we believe significant recovery happens in thriving relationships. When survivor leaders can access affirmative community love and care, form connections, and engage meaningfully in co-creating healing and learning spaces, it reinforces their sense of individual agency. Some of our collective healing practices include monthly art psychotherapy, collective journaling, guided venting sessions, sound therapy, dance therapy, and group debriefing to name just a few.

What Long-Term Trauma Symptoms do the Collective Healing Approaches Address?
In recent research conducted by survivor leaders at Azadi, focusing on the effects of trafficking on the mental health of people with lived experience in Kenya, the findings identified that survivors of human trafficking go through both long-term and short-term mental health challenges. If these needs aren't attended to, they might develop severe long-term mental health concerns. The most common effects associated with human trafficking included depression, drug and substance use, shame, guilt, suicidal and self-blame ideologies, feelings of hopelessness, fear of strangers, loss of appetite, lack of interest in things one initially had interest in, and sleeping disorders including insomnia and nightmares.

The research established that people with lived experiences have difficulty forming and sustaining relationships due to unique barriers to self-expression and the capacity to take up space. Other respondents reported that family or friends can easily re-trigger memories about the abuse or the abuser. People with lived experience are often plagued with deep shame, guilt, feelings of unworthiness, and alienation. Survivors are therefore unable to access relevant relational and familial support.

Trafficking is a form of abuse that involves polyvictimsation, where survivors experience multiple types of victimisation, such as physical abuse, verbal abuse, and sexual abuse.

It is an alienating form of abuse that impacts not just survivors' bodies but also causes an internal self-mistrust, detaching survivors from their sense of self and safety, and dramatically shifting their view of self and the world. Survivors sometimes may not talk about their experiences after trafficking, leading to accumulated resentment, anger, urge for revenge, loss of hope, and a multitude of emotions experienced simultaneously, which can go unaddressed for a long time. Mostly, society assumes that being out of the trafficking situation and providing short-term solutions like accommodation is enough, thus subjecting survivors to more harm when they do not fully integrate.

This significantly derails survivors' capacity for personal growth, development, and healing as a consequence of being in survival mode throughout the period of abuse and long after rescue. Upon rescue, survivors of long-term trauma are forced to invest their time and energy in relearning primary psychological functions, such as the feeling of safety, and transitioning out of survival mode to redefine their sense of self and relearn their own emotional accessibility. The incapacity to grow socially or psychologically and to connect significantly influences the human functions of people with lived experience.

Human functions like self-attunement, expression, self-regulation, meaningfully exerting oneself, taking up space, and allowing for one's authenticity to emerge are often diminished as a result of the high-level trauma.

How are the Care Practises helpful for Long-Term Integration into Society?
At Azadi, we view the treatment of trauma as part of the process rather than the outcome of our programming. The goal of our well-being activities includes healing but does not stop there; we continue to inquire and imagine what it means to live a fulfilled life.

Collective healing practices provide a necessary opportunity for purposefully holding space for communal trust and safety, addressing both individual and collective trauma, accessing mutual peer support, and consistently validating survivors' responses to trauma. Our wide range of therapeutic models ensures that the community has ready access to modes of care that nourish their minds, bodies, and spirits.

Collective healing practices create a platform for relationship-building, providing survivors with a community where they can lean on each other and establish a long-term support system.

These practices are implemented to enlighten survivors and all community members on how to better deal with the difficult triggers, find peace within themselves and others, and engage effectively with the community without causing harm.

Faith Wanjiku Mwangi
is a human rights advocate, a feminist, a protection practitioner and currently working as the Managing Director at Azadi, a survivor-led organisation in Kenya. She has worked in counter trafficking for the past five years. Faith has a Bachelor of Science from Egerton University, a Diploma in Community Development and Certificates in Project Management and Global Mental health from the University of Washington.

Linzy Livian Otieno
is a therapist, survivor advocate, feminist and researcher studying Gender Based Violence, Human Trafficking and Child Sexual Assault. She has extensive experience in implementation, mental health activities, mentorship training, and outreach and advocacy. She has worked with organisations including Azadi Kenya and National Survivor Network, OPBLUE. Linzy is pursuing a Bachelor's Degree in Counselling Psychology from Mount Kenya University.

Assessing the Effectiveness of the Mental Health Equity Global Agenda for Low- and Middle-Income Countries

MNS
Mental, Neurological, and Substance Use

MHL
Mental Health Literacy

MHLeC
Mental Health Literacy e-Curriculum

MHLq
Mental Health Literacy Questionnaire

LMIC
Low- and Middle-Income Countries

Merits of Bottom-Up Approach to Mental Health Research: A Study in Malawi

GLORIA CHIRWA
JOEL NYALI
SANDRA JUMBE
Malawi

Poverty and Mental Health in Low- and Middle-Income Countries (LMICs)

Mental health concerns are prevalent among the poor around the world,[1] with mental, neurological, and substance use (MNS) conditions significantly contributing to morbidity and early mortality.[2] A systematic review of adolescent substance use in sub-Saharan Africa found a 42% overall prevalence,[3] with over 75% of individuals with MNS problems unable to access necessary care or therapy.[4] In Malawi, a low-income country, depression is prevalent among adolescents, with rates as high as 20%.[5] Globally, disparities in access to healthcare, particularly among youth living in poverty,[6] amplify limited treatment access for, poor knowledge of, and negative attitudes towards mental health concerns.[7] Poverty significantly impacts mental health, especially during adolescence and early adulthood, where disorders often emerge and impact psychosocial development and adulthood transitions.[8] Although the treatment of MNS conditions among youth is a priority for global mental health, its top-down approach does not fully benefit the poor Malawian youth.

The Mental Health Literacy e-Curriculum (MHLeC) research project in Malawi demonstrates how empowering grassroots organisations in mental health research can shape constructive critiques of the treatment agenda for MNS conditions in LMICs.

Mental Health Data on Malawian Youth

Even though half of Malawi's population is aged 18 years or below,[9] the youth here are marginalised in mental healthcare.[10] For instance, there are no specialist youth-centred mental health services in the only three hospitals providing mental healthcare in the country.[11] There is no policy on mental healthcare for children and youth. There is a lack of epidemiological data on MNS conditions among youth in the country, and so knowledge and data about it are limited. Our initial qualitative study involving focus group discussions with youth and youth-led organisations across the country uncovered a vicious circle of mental health concerns and poverty among young individuals in Malawi as well as the shortcomings of the nation's health system that impede youth-focused mental health support services.[12]

To assess mental health literacy (MHL) among Malawian youth, we conducted a cross-sectional national survey using a self-reporting MHL questionnaire (MHLq).[13] The questionnaire assessed knowledge of mental health concerns, false beliefs/stereotypes, first-aid skills, help-seeking behaviour, and self-help strategies among 682 young adults (16 to 30 years old) in 13 districts of Malawi in both rural and urban communities. We translated the questionnaire into Chichewa, Malawi's official local language, to increase the participation of people with low English literacy.

Individuals with MNS problems unable to access necessary care or therapy

The survey found that most responders were either jobless (36%) or enrolled in education (43%).

Among those surveyed, 73% had finished their primary or secondary school.

While 48% knew someone who had experienced mental health concerns, only 14% could name the condition.

The average MHL score for this cohort was comparable to previous European cohorts used to develop the questionnaire. However, Factor 2 (erroneous beliefs/ stereotypes) and Factor 3 (first-aid skills and assistance-seeking behaviour) scores of the questionnaire were considerably lower for those with primary and secondary school credentials than for those with higher education. Assessing MHL in Malawian communities helped us identify gaps and informed the development of MHL- and evidence-based interventions.

The MHLeC Project

To address some of the gaps we identified in MHL, we carried out a pilot study that culturally modified an existing programme[14] into an e-course for youth in Malawian universities.[15] This was done in several ways.

First, by incorporating key issues raised by our youth respondents – relationship issues, types of mental health concerns, and finding sources of support – into the existing content.

Second, to address language barriers, we translated the names of different mental health concerns into Chichewa.

Third, to target the issue of 'erroneous beliefs' and negative stereotyping of mental health concerns and to instead normalise them, we included lived experience videos from Malawian and other African contexts.

Fourth, to tackle the issue of low first-aid skills and help-seeking behaviour, we included a catalogue of vetted local grassroots organisations providing free psychosocial support and counselling to young people.

We also revised some questions in our pre- and post-evaluation questionnaires to fit the Malawian context.[16] For instance, we replaced the word 'teen', not commonly used in Malawi, with 'young person' or 'adolescent'. A key aspect of cultural adaptation was sharing the initial e-course prototype with various grassroots youth groups through stakeholder workshop discussions and revising it based on their feedback. This proactive community engagement enabled us to learn about and incorporate pertinent perspectives that guided the creation of mental health interventions tailored to our target demographic.[17] We anticipated three outcomes from the study, namely, enhanced understanding of mental health, decreased stigma, and enhanced help-seeking ability among workshop attendees.[18]

Additionally, in our national survey we found that respondents with higher education attainment had higher MHLq scores.[19] This suggests that the longer-term effects of rolling out the MHLeC nationally could include a population-level rise in MHL as well as a reduced strain on an already overburdened healthcare system and medical personnel.[20]

The Agenda on Treatment of MNS Conditions in LMICs

The World Health Organization recently issued new and updated recommendations on the treatment of MNS conditions, with some of them focusing on youth, women, and girls. These evidence-based recommendations have been commended as essential in helping primary healthcare providers' treatment of patients with MNS conditions.[21] The recommendations are also reported to have been made based on systematic evidence reviews, among other methods, and to have taken into account several factors, including the balance between desirable and undesirable effects; values and preferences of intended users of the intervention; resource requirements and cost-effectiveness; health equity, equality, and non-discrimination; feasibility; and human rights and sociocultural acceptability.[22]

Although the new and updated recommendations aim to contribute towards equitable mental health for all, it is a top-down approach that may not work for all contexts in the LMICs, despite using systematic evidence reviews to develop them. Malawi, for instance, does not have sufficient data on mental health, specifically on MNS conditions. The systematic evidence reviews presumably used a common measure of mental health in sub-Saharan Africa or Southern Africa, which may not accurately reflect the MNS conditions and the awareness of these among Malawians for them to seek treatment, given the limited data available. **For example, mental health concerns in Malawi are fuelled and/or made worse by poverty. This aspect is not considered enough in the current global mental health agenda.**

Looking to the Future

The MHLeC project is a good example of how if more people from grassroots organisations in LMICs are empowered or enabled to be more directly involved in mental health research, it can shape constructive critiques of treatment agendas in LMICs with a better understanding of their unique cultural contexts. This in turn will foster more effective interventions that feed into the goal of equitable mental health for all. Solutions on MNS therefore need to be developed from a bottom-up approach that allow an in-depth analysis of each country's landscape. Needless to say, this bottom-up approach could be more effective with the LMICs' political will and sufficient government resources for mental health research. For instance, Malawi has perpetually kept the budget for mental health services at 1% of the total national health budget.[23] With such meagre resources and investment, the ability of programmes like the MHLeC project to be able to challenge or influence structures of power at the top remains questionable.

Gloria Chirwa is a social scientist from the University of Malawi. With eight years' experience in youth development work, she aims to understand the challenges faced by Malawian youth and implement evidence-based youth development programmes. Gloria works in mental health research at the School of Health and Social Sciences, Millennium University, Malawi.

Joel Nyali is a development economist by training, currently working on a youth mental health research project at Millennium University, through which he hopes to contribute to improved youth health outcomes in Malawi. He is also an aspiring health economist, hoping to contribute to the country's health system and policy through his work in youth health programming.

Sandra Jumbe is a health psychologist, trained at UWE Bristol, United Kingdom. As an African Research Initiative for Scientific Excellence, or ARISE, fellow funded by the African Academy of Sciences, she leads the Mental Health Literacy e-Curriculum project at Millennium University. She is also an NIHR Research Support Service Methods Advisor at Queen Mary University.

Fostering Mental Healthcare in a Postcolonial Continent with Digital Medicine

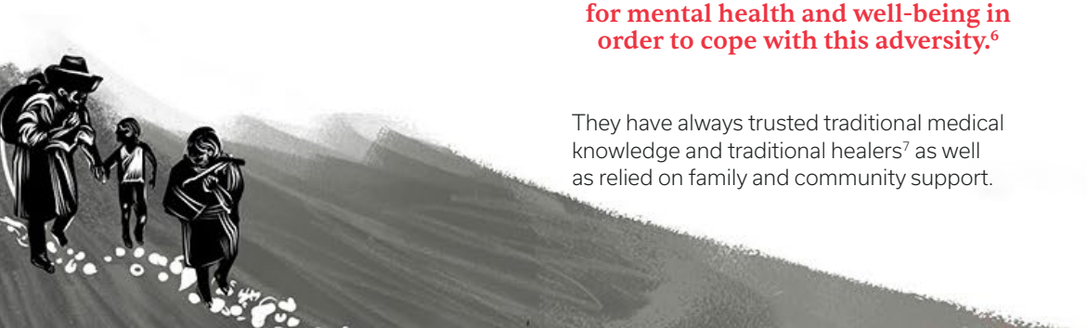
New Road to Care by the Indigenous Peoples of South America

MARIO INCAYAWAR, LISE BOUCHARD, AND SIOUI MALDONADO-BOUCHARD
Peru and Canada

Access to conventional, Western-oriented mental healthcare in a colonised continent is a formidable challenge. In South America, after more than 500 years of colonisation, first by the Spanish and then by the Mishu (the name of the oppressor in the language of the Incas) that is ongoing, Indigenous Peoples struggle to obtain the most basic psychiatric ca

A majority of Indigenous Peoples do not visit a mental healthcare professional as no country in the region has developed a dedicated and accessible mental health system for them.[1]

Nevertheless, they have successfully survived atrocious violence, dispossession, serfdom, racism, and systemic discrimination perpetrated by the Mishu without the support of any Western-trained mental health professionals. But new digital mental health technologies have the potential to allow Indigenous Peoples to bypass postcolonial barriers and access mental healthcare.



The Indigenous Peoples of South America – Living without Psychiatrists

In the fifteenth century, Spanish armies invaded and subjugated the Indigenous Peoples and instigated a devastating regime of oppression and dispossession.[2] Since the nineteenth century, the ruling **Mishu – people of mixed Spanish and Indigenous ancestry who identify as white Westerners and repudiate their Indigenous roots** – have replaced the Spaniards as perpetrators. This long-lasting colonisation has transformed the Indigenous Peoples into one of the most impoverished and dispossessed peoples in the world.[3] Currently, it is estimated that 30 million Indigenous Peoples live in the region and 420 languages are spoken. The Indigenous Peoples have not been able to expel the colonisers and repossess their homeland as in Asia and Africa. In the present-day postcolonial era, there is a caste-like social stratification that, along with the political structure, marginalises Indigenous Peoples, discriminates through institutionalised racism,[4] and creates severe health inequities.[5]

Despite centuries of oppression, Indigenous Peoples of South America have shown exceptional resilience and self-sufficiency, continuing to nurture their traditional resources for mental health and well-being in order to cope with this adversity.[6]

They have always trusted traditional medical knowledge and traditional healers[7] as well as relied on family and community support.

Mental Health Status

The Outrageous Neglect and Calls for a Moral Case

Little is known about the mental health status of the Indigenous Peoples of South America or their psychological needs, with only a handful of scientific papers on the subject. The World Health Organization (WHO) has published only one small booklet on the mental health of the Indigenous Peoples around the globe, in which South America is briefly mentioned.[8]

Though the Pan American Health Organization (PAHO), WHO has created the Health of the Indigenous Peoples of the Americas Initiative, followed by similar initiatives in several countries, there is no mention of mental health. In 1998, PAHO sponsored an international workshop called 'Mental Health Programmes and Services for the Indigenous Communities' in Bolivia. Twenty-five years later, no specific programme of mental health designed for the Indigenous Peoples exists.

Referring to the neglect of mental health worldwide, Arthur Kleiman from Harvard University suggests not to wait for studies but to instead build a moral case.[9] As much is true for the pervasively overlooked mental healthcare needs of the Indigenous Peoples of South America.

Mishu Healthcare Workers' Biased Care

Postcolonial perspectives view the Indigenous Peoples of South America as backward, subhuman, dirty, prone to spread disease or violence, and a barrier to progress.[10] The WHO reported in 1999 that Indigenous Peoples are racially discriminated against and are treated as second-class citizens and inferiors.[11] Mishu psychiatrists and other mental health professionals more often than not embrace these biases. This makes for failed medical encounters between Mishu practitioners – who largely only speak Spanish and might be hostile, patronising, and racist – and the Indigenous clients – who might not speak the dominant languages of Spanish or Portuguese and might be suspicious, distrustful, and fearful.

Troublesome Perceived Empathy and Healthcare Refusal

Empathy perceived in physicians has a positive effect on patients' experience, both at physical and biological levels.[12] In South America's long sociohistorical context of colonialism, even well-meaning clinicians are likely to be perceived as threatening by Indigenous patients. The mistrust, which has helped Indigenous Peoples survive centuries of oppression and unlikely to wither away, can lead to miscommunication, gaps in critical information gathered to make proper diagnoses and treatment plans, and poor adherence to treatment. And this is in the best, albeit rare, scenario – when an Indigenous patient *does* go see a clinician, and the clinician *is* in fact sensitive, well-meaning, and cognisant of their biases.

Digital Medicine for Blunting Barriers to Care?

In this historical, sociopolitical, and medical context, it is hard for an Indigenous patient to find suitable pathways to mental healthcare. Unwittingly, the new digital mental health technology could allow Indigenous patients to bypass this colonialist healthcare system.

The Arrival of Cell Phones Bypassing Discrimination and Racism

A foreign resident waiting to make a phone call in a small town in the Andes in the 1980s experienced the following. The Mishu operator ignored the Indigenous women in line and aimed to serve the foreigner first. When the white woman insisted that the operator serve people in the order they arrived, the operator, though angry, reluctantly then served the Indigenous women. For the operator, it was normal to serve Indigenous People last.

Fortunately, some 20 years later, an unexpected social phenomenon occurred in the Andes with the arrival of cell phones. Until then, owning a telephone landline was a privilege for a few wealthy Mishu people. Indigenous Peoples had to go to the telecommunication office, wait to make a call, and be at the mercy of the operator's will. Unexpectedly, the cell phone brought a quick democratisation of telecommunications, and Indigenous Peoples were able to make phone calls as they pleased on their own cell phones.

Likewise, the arrival of smartphones in the Indigenous communities of South America and the development of digital mental health technologies, which include self-help courses and AI software, may allow Indigenous Peoples to gain empowerment with regards to mental healthcare.

The Promising Contribution of Digital Mental Health

With digital mental healthcare, be it personalised mental health apps or platforms, Indigenous Peoples could have access to more equitable care, avoiding the discriminatory hurdles of the system in place. Although digital mental health services are often considered more impersonal, Indigenous Peoples may find this to be of comfort, reducing their exposure to hurtful interactions. Safety and privacy issues notwithstanding, digital mental health could have a beneficial impact on the betterment of the mental health of colonised and marginalised populations.

As physicians, we like to believe that high-quality medical care is based on good human interaction between patients and practitioners. However, when these interactions are tarnished by conscious or unconscious social and racial biases, the service provided by healthcare practitioners will be of poor quality, unequal, and unjust. Although the new developments of artificial intelligence in medicine are viewed with caution,[13] it could be a promising pathway to care for the marginalised Indigenous Peoples of South America.

Despite more than five centuries of colonisation, Indigenous Peoples in South America have adapted to new challenges and adversity. In the near future, they may likely find their own ways of integrating digital technology to access mental healthcare.

Mario Incayawar
M.D., M.Sc, DESS., Ph.D.
is an Inca physician-scientist and an educator. He is the recipient of the John Simon Guggenheim Fellowship 2006. Founder and director of Runajambi Institute – Personalized Medicine for the Indigenous Peoples of the Americas, he also held the Henry R. Luce Professorship at the Claremont Colleges, California and the William F. Quillian Jr. International Professorship at R-MWC, Virginia.

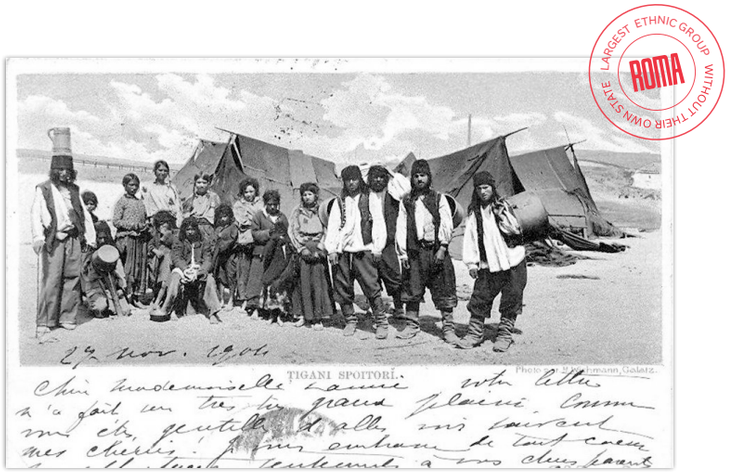
Lise Bouchard
M.A., Ph.D.
is a linguist-anthropologist interested in Quichua-Spanish contact and exploring the interplay between linguistics, medicine, psychiatry, and anthropology. She has a B.Sc. in Anthropology and Linguistics from Université de Montréal, Canada and an M.A. and Ph.D. in Linguistics from Université du Québec à Montréal. She is the co-founder and director of research at Runajambi Institute.

Sioui Maldonado-Bouchard
M.D., M.Sc., Ph.D.
is a psychiatry resident at McGill University, Canada. She completed B.Sc. and M.Sc. in Psychology at Université de Montréal, PhD in Neuroscience at Texas A&M University, and a post-doctoral fellowship in Social Modulation of Pain at McGill University. She is interested in the intersection between social environment, mental health, and the role of empathy in both mental illness and therapeutic alliance.

Tackling Mental Health Inequalities for Roma Communities in the UK

This Article Examines Tackling Mental Health Inequalities for Roma Communities in the UK Through the Mental Health Advocacy and Research Work of the Roma Support Group.

SIMINA NEAGU & MIHAI CALIN BICA
United Kingdom



Context

In response to "Global Mental Health from the Margins," we write from the Global North, focusing on a migrant community from the Global South. The **Roma** Support Group (RSG) aids those who[1] arrived in the UK as asylum seekers in the 1990s and as economic migrants after the 2004 and 2007 European Union accessions.

We write from London, home to one of the most diverse **Roma** communities and the 1971 First World Romani Congress, where the **Roma** flag and International Day were adopted. London is also notable for hosting the world's first mental health asylum, the Priory of St. Mary of Bethlehem, established in 1247. Thus, we write from a place of community empowerment and self-determination, as well as a foundational site for Western psychiatry, with all of its limitations and problems. One issue is the context of Global Mental Health (GMH) – which invisibilises **Roma** mental health access and equity due to the simplistic presumption that 'vulnerable populations' are only present in low and middle-income countries (LMICs). In addition, the GMH focus on scale rather than rights poses particular challenges in addressing mental health gaps for **Roma** and other marginalised communities in high-income countries (HICs).

The Roma Community

To understand this group's mental health, we must acknowledge the **Roma** community's ethnic identity, migrant profile, and restricted access to public services in their countries of origin. '**Roma**' refers to a diverse population of 10–12 million people globally. They originate from the Indian subcontinent, with the largest populations in Bulgaria, Hungary, Romania, and Slovakia. A 2012 genetic study by Indian and Estonian geneticists confirmed their link to traditional scheduled caste and tribe groups in Northwestern India.[2] Parallels have been drawn between the **Roma** in Europe and Dalits in India, including the Dalit-**Roma** Initiative by Dr Margareta Matache and Dr Suraj Yengde.[3]

Roma communities across Europe have distinct tribal affiliations, speak various languages, and follow different religions. They are the largest ethnic group without their own state, often leading to a lack of recognition as an ethnic minority.[4]

Throughout their history, the **Roma** have endured marginalisation and oppression as they encountered various societies. Often viewed with suspicion by non-**Roma**, they have suffered enslavement, abuse, and forced expulsion during their extensive migration across Europe. Notably, **Roma** Slavery in present-day Romania spanned over 500 years,[5] predating the Trans-Atlantic Slave Trade by a century. This shared history draws parallels between the **Roma** experience in Eastern Europe and African Americans in the US.[6] Moreover, the **Roma** faced persecution under the Nazi regime, resulting in an estimated 600,000 murders during the Holocaust. Additionally, coercive sterilisation targeted **Roma** women in Eastern Europe, who were either offered monetary incentives for voluntary sterilisation or were subjected to sterilised without consent during other medical procedures.[7]

In addition to direct deprivation of rights, **Roma** face disadvantages due to discriminatory governmental policies or institutional operating frameworks. For instance, the criminalisation of nomadism in Czechoslovakia in 1958, and Poland in 1964, forced **Roma** into permanent settlements depriving them of their traditional lifestyle and cultural expression rights. Subsequent physical segregation often leaves **Roma** residing in substandard housing without access to basic sanitation. Additionally, schools in Eastern Europe engage in systematic misdiagnosis of learning disabilities to justify the disproportionate placement of **Roma** children in special needs classes, regardless of actual needs.[8]

In the UK context, it is crucial to acknowledge that the **Roma** are a migrant community. Consequently, **Roma** encounters specific challenges such as language barriers, navigating UK public service systems, and ensuring the security of their immigration status. These factors can significantly impact the mental health of **Roma** community members.

Roma Mental Health

Roma communities are classified as an inclusion health group due to their social exclusion and multiple overlapping risk factors for poor health. According to a study by the European Public Health Alliance, **Roma** life expectancy in the UK is reported to be up to 10 years lower compared to non-**Roma** communities.[9]

Although protected under the Equality Act 2010, **Roma** individuals in the UK face obstacles in accessing health services, such as registration refusal, discrimination, digital exclusion, language and literacy barriers, administrative hurdles, lack of cultural sensitivity, and stigma.

Mental health services must build trust by tailoring their approach, including cultural awareness, interpreters, non-digital options, collaboration with community organisations, and integrated support throughout treatment.

It is vital to ensure non-Roma professionals, whether mental health practitioners or interpreters, do not hold discriminatory views, as these affect therapeutic relationships.

Limited contact with health services could result in many **Roma** individuals having little information about prevention, often seeking help only in crisis. Poor housing or environmental conditions can exacerbate physical and mental health concerns, including stress, anxiety and depression.[10] Consequently, the tools, questionnaires, scales, and language used in global mental health may be as inappropriate for **Roma** communities as for those in LMICs.

Mental health issues among **Roma** are worsened by social exclusion, discrimination, stigma, or racist attacks. Many needing support live in families facing complex problems, requiring holistic approaches and additional support.

A persistent cultural stigma surrounds mental health in the **Roma** community [11] discouraging open discussion. Many rely on relating daily issues to well-being or expressing stress and worry. Mental health remains taboo, hindering open discourse and prompting fear of institutionalisation or discrimination when seeking professional help. Awareness of mental health shifts among youth but has not yet translated to open discussions in the community.

Simultaneously, in their countries of origin, there is a lack of disaggregated data on **Roma** people's access to mental health services. Nonetheless, research indicates that 'the **Roma** are often at higher risk of experiencing poor mental health and suffering from stress, depression, or anxiety, given their ongoing state of poverty, deprivation, and marginalisation'.[12]

Although there is increasing recognition of what **Roma** populations suffered before, during, and after the Holocaust, a historical perspective exploring the legacy of these experiences for **Roma** is largely absent from research.[13] The presence of intergenerational approaches would help to unpack the trauma and its mental and physical health impacts as it has been transmitted over decades.[14] As Eamon M. Anderson observed, 'the impacts of massive group trauma may be transmitted inter-generationally through learned adaptive behaviour (survival coping), through genetic/epigenetic means, and through power-imbalanced systems which replicate groups' low social status,'[15] and that historical trauma has effects on multiple levels, from individual, family, to community levels. Ironically, trauma research is overwhelmingly HIC research even as they leave out the **Roma** community's experiences of trauma and oppression that are historical, intergenerational and parallel day by day.

Hence, creating trauma-informed, culturally sensitive, and historically aware mental health services is essential for **Roma**, migrant, and traveller communities across the UK and globally.

For more details about **Roma** health, please see RSG's Roma Health Guide.[16]

Simina Neagu is Roma Support Group's Mental Health Project Coordinator and works on the VCSE Health & Well-being Alliance project.

Mihai Calin Bica is Roma Support Groups' Campaigns and Policy Coordinator and coordinates the organisation's work on the VCSE Health & Well-being Alliance project.

'Within these prison walls,
we are unseen and unheard,
our minds struggle in silence.

Behind these bars,
our mental health deteriorates,
and we fall into deep despair.'

An incarcerated person during a mental health intervention in one of India's prisons

Behind Bars

Mental Health and Incarceration: A Note from Bihar

GURUDEV NANDA
Bihar

Introduction

The determinants of mental health are vastly different across regions, situations, and individuals. They are even more distinct for prisoners, as their experiences behind bars are shaped by factors almost entirely outside the ambit of 'normal' society. But global mental health often overlooks the different ways in which people experience mental well-being or the lack of it and especially disregards the plight of prisoners.

Mental health as a global concern has gained significant attention in recent years. The fundamental aim of global mental health is to promote mental well-being and healthcare for everyone across the world as well as encourage holistic approaches to mental health values and human rights.[1] However, although global mental health aims at promoting inclusive, equal access to mental healthcare, these principles are not adequately implemented, especially when it comes to those in prison. There is a higher prevalence of mental illness among prisoners compared to the non-incarcerated population across the world. This might be due to several factors such as socioeconomic disadvantage, histories of trauma, substance abuse, lack of access to mental healthcare, social stigma associated with mental health, overcrowding in prisons, and lack of mental health awareness among prison officials.

In India too, incarcerated individuals continue to face inadequate mental healthcare as well as lack access to it.

Additionally, in India, the inequalities perpetuated by the caste system significantly affect mental well-being, as marginalised individuals face systemic discrimination and limited access to resources. However, global mental health efforts tend to prioritise issues that are more universally recognised, often overlooking the unique challenges of region-specific issues. This extends to marginalised individuals in prisons too, where too caste operates, and so their mental well-being suffers even more. The lack of acknowledgment of societal inequities and the non-inclusion of prisoners' well-being in global mental health discourse perpetuate the marginalisation of affected communities and undermine efforts to address mental health disparities on a global scale.

This essay strives to explore prisoners' mental health as a global mental health concern. In addition, this piece will elaborate on a story of a prisoner from the lens of mental health within correctional institutions.

Mental Health in Bihar's Prisons

In the state of Bihar, prisons are significantly overcrowded, exceeding their capacity by over 19,000 inmates, which contributes to compromised living standards, limited access to healthcare resources and recreational activities, lack of mental health facilities, etc.[2] These factors increase tensions among inmates and impact their overall well-being.[3] According to Prison Statistics India's 2021 report,

80% of unnatural death among prisoners are suicides and are predominantly linked to mental health concerns.[4]

As a social worker, I frequently provide prisoners with the necessary assistance to enhance their mental health. During my visits and interaction with prisoners, I have observed that incarceration compounds the feeling of isolation and stigmatises the individual, hampering their mental health. A former prisoner said, 'Once you're in jail, everything is over. People call you a criminal.' When individuals leave prison, they are stigmatised, discriminated against, and treated badly in society.[5] This fear of social rejection adds to the prisoners' deteriorating mental health. Moreover, the stigma and labelling associated with seeking mental healthcare contribute to prisoners' reluctance to receive the necessary treatment and support.[6] The absence of awareness about mental health and the care options is yet another barrier to addressing mental health concerns of incarcerated individuals.

From my interactions with prisoners experiencing mental health challenges, I learned that both first-time incarceration and long-term incarceration severely affect the mental health of prisoners. Separation from loved ones exacerbate these issues and cause emotional damage. In such a situation, a non-judgemental listener becomes important for the prisoners to freely share their thoughts and feelings with.

I met Amit Kumar (name changed), a twenty-year-old incarcerated in Phulwari District Jail in Bihar's Patna city. Though he was initially reluctant to share his experiences and concerns, after multiple interactions, he spoke about his case and his family circumstances and asked for legal assistance. His imprisonment had compelled his elderly mother to sell balloons for survival.

I was the sole earner in my family, but I have been in jail for so long. This worries me. I don't feel like eating. I feel angry. I feel strange. Amit Kumar

I acknowledged all that he was experiencing and listened to him. During each visit, I tried to involve him in activities like storytelling and singing songs and tried to make him laugh. I observed a noticeable change in his behaviour and overall well-being.

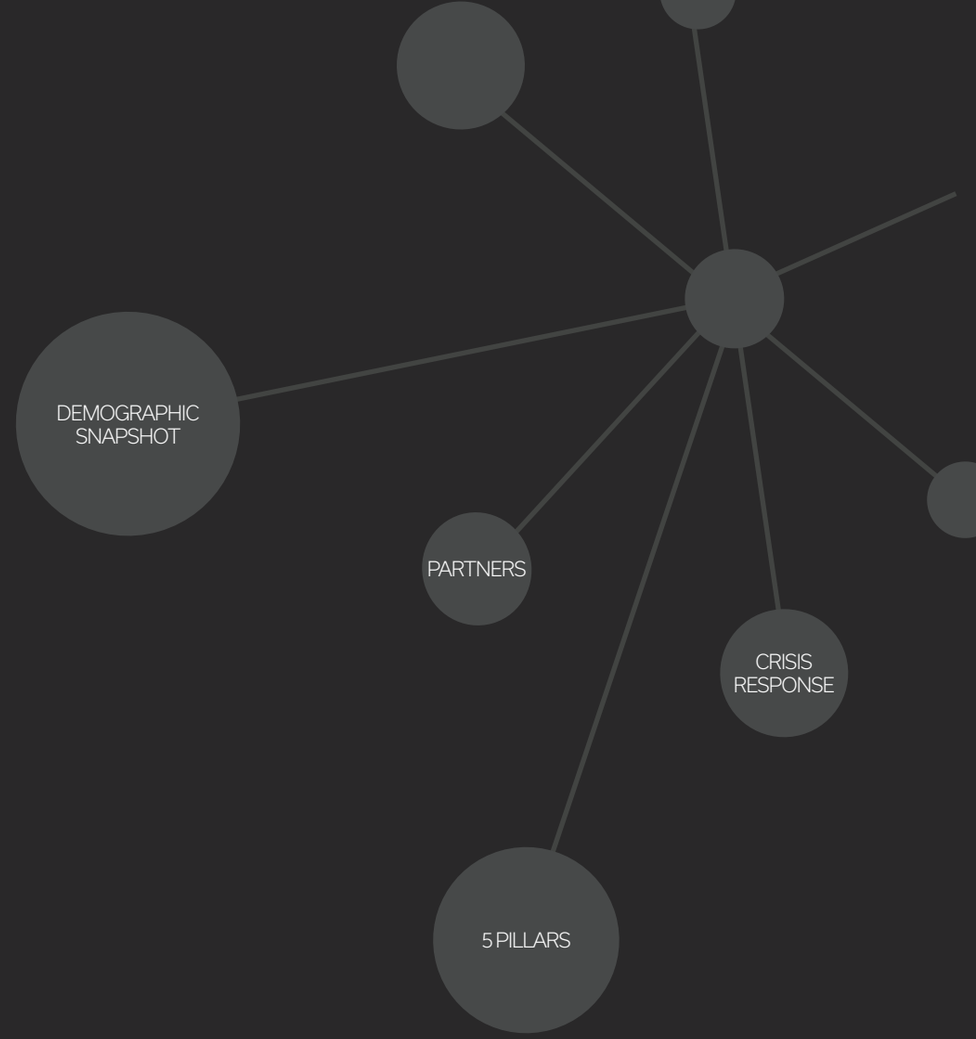
This story not only highlights the mental health impact of incarceration and being separated from family members but also the significance of mental health support and the positive changes it can bring about in prison environments. Undertaking interventions to improve the mental well-being of prisoners is crucial.

Conclusion

Incarcerated individuals often face more challenges to their mental health as well as significant barriers to accessing adequate care, and this is more so in the case of places like Bihar where the prison infrastructure is poor. The stigma surrounding mental health and incarceration exacerbates these challenges and further alienates prisoners. There is a need for comprehensive strategies to address mental health issues in jails. Efforts have to be made to improve the mental health and well-being of incarcerated individuals based on the principles of global mental health, including access to care, stigma reduction, and addressing social determinants.

Gurudev Nanda
is a social worker at the LAW Foundation, is dedicated to enhancing social well-being and mental health in prisons and communities. With an M.A. in Sociology and Social Anthropology from Tata Institute of Social Sciences, Guwahati, he focuses on empowering marginalised communities and promoting equal mental health and social justice opportunities.

MHI'S WORK



Besides fulfilling its primary role as a grantmaking agency, MHI has included various endeavours within its work that utilise its strengths in knowledge creation, communication, and dissemination.

We aim to engage critically with dominant knowledge as well as centre knowledge from the margins in all our initiatives.

ReVision

MHI partnered with the Delhi Commission for Women and iCALL to conduct a two-hour training for counsellors of the 1-8-1 women helpline in January 2023. The session covered concepts of gender-based violence (GBV) and domestic violence, principles of survivor-centred counselling, and self-care. Over 45 counsellors from across Delhi were trained.

MHI CONDUCTING THE HELPLINE COUNSELLOR TRAINING WITH ICALL AND DCW

MHI partnered with the Bihar Institute of Mental Health and Allied Sciences to raise awareness and conduct sensitivity training with the staff between October 2022 and September 2023. Residents were introduced to the importance of self-care and hygiene as well as received introductory training in making products and in financial literacy. In addition, the hospital staff were introduced to the social recovery model to increase their understanding of the rights of persons with mental illness and to improve interactions with residents.

In early 2022, MHI became one of the founding members of the Future Mental Health Collective – a global peer-to-peer network for funders to come together to share, learn and listen to each other about what is working, gaps in the field, and ways to collaborate to reduce duplication, accelerate impact, and supercharge each other's efforts. In keeping with our mandate to increase funding towards mental health, our advocacy efforts led to the Forbes Marshall Foundation and the Rohini Nilekani Philanthropies taking the first steps towards mental health funding. It began with raising funds for four of MHI's partner organisations, following which, the two organisations have ventured into funding other mental health initiatives.

Leadership

MHI director Raj Mariwala was a keynote speaker at the International Association for Youth Mental Health Conference in Copenhagen, October 2022.

RAJ (DIRECTOR, MHI) SPEAKS AT THE IAYMH CONFERENCE

Alongside this, Raj also spoke at Giving Women's 10th Annual Conference in Geneva. MHI CEO Priti Sridhar attended the International Association on Suicide Prevention's Asia Pacific (IASP) Conference in May 2022 in Gold Coast, Australia. Following this, Priti has been an active member of IASP's global events.

Context

In partnership with New Delhi–based Sangath and UK-based Comic Relief, MHI funded and created the DIYouth Advocacy Kit – a free resource to empower young people to advocate for their mental health rights. It was created by a group of young people, mental health experts, advocates, and technologists, including those who have lived experiences of mental health needs. It provides information about fundamental concepts of mental healthcare and related legal provisions in India as well as a step-by-step guide to conceptualise, implement, and evaluate a mental health advocacy initiative.

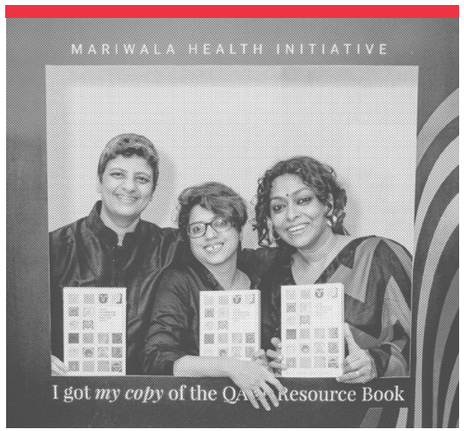
MHI held a workshop for journalists titled 'Reporting on Mental Health: Making It More Impactful' on 22 November 2022. The goal of the workshop was to enhance journalists' understanding of mental health as a psychosocial issue and to build on the intersection of mental health with gender, sexuality, and climate change. The speakers at the workshop included Illa Kulshrestha, clinical psychologist, Achal Bhagat, senior psychiatrist at Apollo Hospital, and Priscilla Giri, researcher at DLR Prerna.

PRITI (CEO, MHI) WITH A REPORTER AT THE REPORTING ON MENTAL HEALTH WORKSHOP

Engage

Strengthening Ecosystems

This year saw two crucial milestones for our Queer Affirmative Counselling Practice (QACP) training programme. First, MHI conducted its initial organisational QACP session with 38 participants from 10 organisations in August 2022. The QACP programme has been designed with the primary purpose of increasing access to affordable therapeutic services for persons from the LGBTQI+ community seeking mental healthcare. MHI engages in the organisational QACP programme with the trust that the participating institutions will observe ethics of practice and care across their work. Second, we concluded the first international batch of QACP for South Asia, Southeast Asia, and Africa through online classes with participants from the Philippines, Indonesia, Malaysia, Sri Lanka, and Kenya in October 2022.



MHI'S QACP FACULTY AND CO-AUTHORS OF THE QACP RESOURCE BOOK (FROM L TO R), SHRUTI, GAURI AND POOJA

Since 2019, QACP has trained over 650 mental health professionals.

In collaboration with the Scheduled Caste/ Scheduled Tribe (SC/ST) student cell at the Indian Institute of Technology, Bombay, MHI conducted a capacity-building session with students in July 2022 to help them mentor the incoming batch of SC/ST students with the aim of providing support and improving their mental well-being. We also worked with them to create a code of conduct and set up referrals for the mentors to access.

MHI partnered with Kislay – a Delhi-based labour union – to implement a unique project aimed at building the mental health and psychosocial support capacities of Kislay's response teams in September 2022. The organisation primarily works with domestic workers and construction workers facing structural oppressions, such as urban poverty, gender discrimination, caste-based discrimination, and lack of labour rights, which lead to mental health concerns connected to domestic violence, child sexual abuse, substance abuse, and trauma

Suicide Prevention

We launched the Suicide Prevention Action training programme in April 2022. It has been designed for social workers and employees of community-based organisations, with the aim of strengthening the service delivery ecosystem as well as enabling the provision of accessible and quality care and support. The programme is currently conducted in English and Hindi.

MHI held a roundtable discussion in August 2022 in New Delhi to advocate for enacting a national suicide prevention policy and discussed strategies for addressing the high rates of suicide among youth. Our advocacy efforts extended to extensive media coverage on suicide prevention with us authoring several articles in mainstream publications as well as engaging in a dedicated content campaign with 'Sanity by Tanmoy', an independent journalism platform on global mental health, on suicide prevention lessons from the Global South. These efforts led to the Indian government launching the first National Suicide Prevention Strategy (NSPS) in November 2022.

Immediately after the release of the NSPS, we held a 'National Consultation on Prioritising Suicide Prevention for Youth in India' with young persons and in collaboration with the Departments of Health, Education, and Youth Affairs in February 2023 to understand from the various ministries on how they would work on the agenda of the NSPS.

MHI supported the Integrated Holistic Health Working Group as part of the Civil 20 (C20) Engagement Group under G20 during India's presidency in 2023. We took the lead in advocating for mental health and suicide prevention during these conferences. As a result of MHI's efforts, both these issues have been included in the overall health objectives recommended to the G20 nations for the first time since the inception of the forum. In addition, MHI also sponsored an international conference as part of the Disability, Equity, Justice Working Group for C20 to advance disability equity and disability inclusion within the G20 leaders' commitments, thereby furthering the Sustainable Development Goals 2030 Agenda to leave no one behind.

MHI ADVOCATING FOR PRIORITISING SUICIDE PREVENTION AT THE C20 CONFERENCE

Conferences Funded

In November 2022, MHI supported MH360° – the Red Door Project's annual flagship event on empowering individuals to explore their emotional distress and make informed choices on how they want to heal, with a firm understanding of societal factors and structural forces that impact their lives. The festival was a mix of conversations, talks, workshops, and public participation events, with a special focus on marginalised voices. MHI supported the Dance Movement Therapy Summit for Change organised by Kolkata Sanved in January 2023. The event brought together multiple stakeholders – such as Dance Movement Therapy (DMT) and Creative Art Therapy (CAT) practitioners; professionals from the fields of public health, mental health, education, and social development; civil society organisations; government officials; academicians; and donor organisations – to explore the scope of DMT and CAT practice in India and work towards their expansion.

MHI funded the 7th National Conference of the World Association for Psychosocial Rehabilitation – Indian Chapter on the theme 'Promoting Rights and Recovery in Mental Health' organised by Lokopriya Gopinath Bordoloi Regional Institute of Mental Health, Tezpur, Assam in March 2023. The event, attended by mental health professionals, academics, and doctors managing community-based initiatives, focused on centring lived experiences, user agency, a rights-based approach, informed consent, community-based rehabilitation, de-institutionalisation, and psychosocial referrals and linkages.

PRITI WITH MHI PARTNERS AT THE WORLD ASSOCIATION FOR PSYCHOSOCIAL REHABILITATION CONFERENCE

Primary Impact Map

Crisis Response

Assam Flood Relief

In June 2022, annual monsoon rains, compounded by deforestation, rapid urbanisation, and insufficient infrastructure led to widespread inundation in the state of Assam, displacing millions and inflicting significant damage.

Despite the recurring nature of floods in Assam, authorities remained ill-prepared to handle the magnitude of the situation. The lack of sufficient relief measures, slow evacuation processes, and inadequate mental health support exacerbated the suffering of the flood-affected population.

3,931 FAMILIES REACHED

For MHI, this meant that its relief efforts had to go beyond mental health support. We funded food rations, medicines, and hygiene kits and prioritised funding communities marginalised by caste.

We provided relief support to:

- ○ Dena Rural Foundation
- ○ Galaxy Social Welfare Organization
- ○ Human Rights NGO
- ○ Jan Briddhi Foundation
- ○ Purva Bharati Educational Trust
- ○ Dhagha, Silchar
- ○ YuMetta Foundation
- ○ All India Peoples Science Network

Manipur Crisis Relief

In the wake of the humanitarian crisis that emerged in Manipur from 3 May 2023 that killed many and left thousands displaced, MHI has been looking to provide relief support to organisations that work with marginalised and vulnerable populations that have been affected by the ethnic discord. We operate on the principle that a rights-based approach to mental health work also involves providing essential services to those without access. Therefore, we have committed to creating access to basic needs in this time of crisis for marginalised communities (SC/ST/OBC, Indigenous/Tribal, Youth and Elderly) who have taken shelter in relief camps.

13,470 PEOPLE REACHED

285+ FAMILIES SUPPORTED

Relief support provided:
We have so far provided funds to seven community-based organisations and one collective carrying out relief work and crisis intervention on the ground in Manipur.

MATAI SOCIETY
KUKI STUDENTS ASSOCIATION
NESDI-RNBA (RONGMEI NAGA BAPTIST ASSOCIATION)
YUMETTA FOUNDATION
CENTRE FOR WOMEN AND GIRLS
BETHESDA-KHANKHO FOUNDATION
KHAMS ZOTAL

Materials provided:

- ☒ Ration
- ☒ Medical kits
- ☒ Sanitary products
- ☒ Clothes
- ☒ Blankets and mattresses
- ☒ Books and stationery

Demographic Snapshot

TOTAL REACH OF OUR PARTNERS

MHI goals include reaching out to and making mental health accessible to marginalised populations and communities. To bridge the mental healthcare gap for persons facing structural oppression, it is even more important to provide psychosocial interventions and support.

44,271
sc/st/obc/ indigenous & tribal communities
CASTE

85,294
ECONOMICALLY MARGINALISED

95,951
women

2,457
lgbtqi+
GENDER

3,837
DISABILITY

38,261
youth
AGE

8,422
RELIGIOUS MINORITY

31,281
ANY OTHER

389,040
sum of persons impacted

MHI uses a 360 degree approach comprising of 5 pillars to support quantum change and encourage innovation, scalability, and capacity building.

5 Pillars

93,125
PERSONS IMPACTED

Effective Service Delivery

Overall, there is minimal access to mental health services, which are marked by both poor availability as well as poor quality. Accessible, holistic, rights-based services in multiple delivery formats need to be made available to all.

8,707
PERSONS IMPACTED

4,366
INTERVENTIONS

References and Linkages

Strong linkages need to be forged between mental health service providers and allied services concerned with livelihood, health, gender, sexuality, education, legal support, and government welfare schemes.

36,233
PERSONS IMPACTED

Capacity Building

Building the capacity of individuals, organisations, communities, and institutions through training and knowledge sharing is of critical importance.

250,966
PERSONS IMPACTED

Awareness

Lack of information combined with stigma around mental health inhibits persons with mental health needs from approaching friends, family, and mental health professionals for support and care.

9
INTERVENTIONS

Research

A thriving and responsive mental health ecosystem must rest on a support base of research that documents and records context and community-specific experiences in the field, along with evaluating the efficacy and impact of a variety of interventions.

PARTNERS

As of 30 June 2023, MHI works with 38 partners across 46 projects in 22 states and 23 languages with communities, institutions, and governments for service delivery, advocacy, de-institutionalisation, capacity building, community mental health, and law and policy.

partners are

- Activists
- Service providers
- Researchers

that affect state & civil society at these levels

- Government
- Institutions
- Communities

MHI'S WORK

	ANJALI
	ANUBHUTI
	BAPU TRUST
	BASIC NEEDS INDIA
	BDS SAMABHABONA
	BEBAAK COLLECTIVE
	BURANS
	CENTRE FOR MENTAL HEALTH LAW AND POLICY, PUNE
	DARJEELING LADENLA ROAD PRERNA (DLR PRERNA)
	DISHA
	JEEVA TRUST
	ICALL PSYCHOSOCIAL HELPLINE
	ISWAR SANKALPA
	KASHMIR LIFELINE
	MAN MARZIYAN
	MANN
	MHAT (MENTAL HEALTH ACTION TRUST)
	MOITRISANJOG
	NIRANGAL
	PARCHHAM
	PROJECT OHANA
	PROJECT SAHYOG
	RAAHI
	RESOURCE CENTRE FOR JUVENILE JUSTICE
	SAMVADA
	SHIVAR FOUNDATION
	SOCIETY FOR NUTRITION, EDUCATION, HEALTH ACTION (SNEHA)
	SUKOON HEALTH
	LISTENING STATION
	WAYVE FOUNDATION
	YA-ALL

LAW Foundation

Since November 2022
BIHAR

Service provider
Communities

Strengthening mental health support and securing rights for prisoners and their families.

LAW Foundation is an NGO in Patna which facilitates access to socio-legal rights of custodial populations belonging to marginalised sections of society. Their thrust is primarily in the areas of legal aid services, networking, researching and documentation, and advocacy of custodial, institutional, legal, constitutional, and fundamental rights of under-trials. LAW Foundation also focuses on the rehabilitation and reintegration of undertrial prisoners from marginalised backgrounds.

Ekjut

Since December 2022
JHARKHAND

Service provider
Communities

Strengthening community based psychosocial interventions to provide care for persons with mental illness and substance use in West Singhbhum.

Ekjut is implementing a comprehensive community-led intervention in West Singhbhum district that will address stressors while including postpartum depression, poor nutritional indicators, GBV, and sorcery accusations as well as addressing common mental health problems and substance use. They are MHI's first partner in Jharkhand and one of the few who work closely with the Indigenous Ho tribes.

Sahjani Shiksha Kendra (SSK)

Since December 2022
UTTAR PRADESH

Service provider
Communities

Providing psychosocial support and mental health awareness to victims of violence and abuse.

Led entirely by women from Dalit and OBC communities, SSK is a feminist organisation that works with adolescent girls and women on literacy and education with a rights-based approach. They create awareness about gender issues related to caste, patriarchy, early/child marriage, violence against women, right to work, and food security in 5 blocks across 250 villages. They also work on legal guidance for survivors of domestic violence/ GBV/rape; provide livelihood support and crisis intervention; and help build access to government schemes/ acts. MHI is currently supporting SSK for a year-long programme on incorporating psychosocial support and legal guidance within their existing interventions as well as on promoting awareness to improve help-seeking behaviour for mental health in the communities they work with.

Nayi Disha Resource Centre

Since January 2023
TELANGANA

Service provider
Communities

Strengthening mental health support and securing rights for prisoners and their families.

Nayi Disha provides resources and mental health support to caregivers of children affected by intellectual and developmental disabilities (IDD). It is a community-led initiative that was started by caregivers of children/family members with intellectual disabilities. They support similar caregivers by disseminating information, forming peer support groups, and enabling access to appropriate resources and a network of experts in multiple languages. Recognising the dearth of mental health support for mothers of children with developmental disabilities in tier 2 cities, Nayi Disha has partnered with MHI to create sustainable communities in Lucknow and Indore by providing them with adequate assistance pertaining to their child, counselling, guidance, and peer community for their own mental health and emotional needs.

Rising Flame

Since January 2023
MAHARASHTRA AND DELHI

Activists, Service provider
Institutions, Communities

Addressing mental health impacts and experiences of persons with disabilities.

Rising Flame is a national award-winning self-led organisation working for the recognition, protection, and promotion of human rights of people with disabilities, particularly women and youth, since 2017. MHI partners with Rising Flame on projects that aim to deepen and build a nuanced understanding of mental health practitioners on mental health of disabled people and spotlight how persistent ableism and discrimination in society has adverse impacts on disabled people. Through developing resources that treat disabled people as experts of their lives, Rising Flame aims to reduce the existing gaps in the understanding around ableism and mental health of all disabled people.

Karuna evam Shanti Vahini Foundation (KeSVF)

Since January 2023
MAHARASHTRA

Service provider
Institutions

Facilitating access to palliative care for marginalized communities in Nandurbar.

KeSVF aims to design and implement interventions that address the inequality in the public health system, specifically in the neglected sectors of palliative and geriatric care. MHI is currently supporting KeSVF to implement a project that intends to facilitate access to palliative care for marginalised communities in Nandurbar district. This project aims to capacitate communities and healthcare providers to respond to distress arising within families on account of serious health suffering and to build an interlinked model of healthcare, including home-based palliative care, that engages with families, communities, and civil society groups as well as public, private, and traditional systems of medicine and health.

Brave Souls Foundation (BSF)

Since April 2023
DELHI

Service provider
Communities

Providing medical assistance, livelihood support, legal aid, and counselling to acid attack survivors.

A community-led organisation founded by an acid attack survivor, BSF has been working for the rehabilitation of acid attack survivors for a decade now. The organisation recognises the deep psychological trauma endured by victims as well as the disabilities they must live with. Therefore, they believe that in order to reintegrate survivors into mainstream society, medical treatment alone is insufficient. In collaboration with MHI, they will extend their work to survivors of acid attacks from Punjab and Haryana. Their efforts will encompass providing medical assistance, livelihood support, legal aid, and counselling to survivors from these states, to ensure they get access to justice and fair compensation.

Signing Hands Foundation (SHF)

Since April 2023
MAHARASHTRA

Service provider
Communities

Creating early educational content for young deaf children.

SHF works to promote deaf or hard-of-hearing people's education, accessibility, awareness, and empowerment. Their holistic and long-term interventions in these fields seek to tackle ingrained development issues and empower the deaf community. MHI and SHF have been partnering for the project 'Education and Awareness for the Deaf Community' since May 2023. SHF will be creating 10 stories of 5 minutes each in Indian Sign Language for children under the age of 5. These stories will be accessible to both deaf and hearing children and will be posted on the YouTube channel ISH Kids.

Trust for Youth and Child Leadership (TYCL)

Since April 2023
PUDUCHERRY

Service provider
Communities

Addressing stressors faced by the youth towards suicide prevention through psychosocial interventions in Puducherry.

TYCL is a community-based youth-led organisation that was founded by three college students in 2009. It focuses on addressing issues such as limited access to quality education, lack of job opportunities, and the need for career guidance, all through a mental health perspective.

TYCL and MHI have partnered to provide support for mental health interventions and suicide prevention work in Puducherry. The project includes a mobile mental health clinic, a youth helpline, and a youth mental health training programme.

Endnotes

Contesting Global Mental Health

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Enough Politeness: Decolonising Mental Health in a Society Oblivious to Its Colonial Wounds

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CANADA
Access to conventional, Western-oriented mental healthcare in a colonised continent is a formidable challenge.
In South America, after more than 500 years of colonisation, first by the Spanish and then by the Mishu (the name of the oppressor in the language of the Incas) that is ongoing, Indigenous Peoples struggle to obtain the most basic psychiatric care. A majority of Indigenous Peoples do not visit a mental healthcare professional as no country in the region has developed a dedicated and accessible
TURKEY
It has been shown that authoritarianism has a direct impact on mental health: they may lead to depressive symptoms, internalisation of oppression, externalisation of self-blame, insecurity in social relations, decrease in sense of safety and control, and hopelessness. Authoritarian regimes also tend to be heteropatriarchal regimes – a socio-political system in which cis-heterosexual males have power over all other identities of gender and sexualities
PALESTINE
The assault on Gaza has left an entire population
KENYA
Upon rescue, survivors of long-term trauma are forced to invest their time and energy in relearning primary psychological functions, such as the feeling of safety, and transitioning out of survival mode to redefine their sense of self and relearn their own emotional accessibility. The incapacity to grow socially or psychologically and to connect significantly influences the human
PERU
Despite centuries of oppression, Indigenous Peoples of South America have shown exceptional resilience and self-sufficiency, continuing to nurture their traditional resources for mental health and well-being in order to cope with this adversity. They have always trusted traditional medical knowledge and traditional healers as well as relied on family and community support. Little is known about the mental health status of the Indigenous Peoples of South America or their psychological needs
MALAWI
For example, mental health concerns in Malawi are fuelled and/or made worse by poverty.

What would it take for Global Mental Health to engage with the displacement, dispossession and urgent needs of persons living under active occupation, genocide, extractivism & colonialism?

mariwala health initiative

mhi.org.in

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/mariwalahealth
/mariwalahealth

022 6648 0500 //
contact@mariwalahealthinitiative.org

Grande Palladium, 8th floor, 175,
CST Road, Kalina, Santa Cruz (E),
Mumbai, Maharashtra 400098