RE FRAME

Unpacking
Structural Determinants

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RE

Unpacking Structural Determinants

FRAME

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Message from the Founder

As this edition of ReFrame goes to print, we know that in this past year, deaths by suicide in India increased by 10% since 2019. This is the highest since 1967, the first year that data was collected. Pandemic related stressors seem to reflect in this data with spikes in death by suicide amongst students, daily-wage workers, the self-employed, and the unemployed. 10 million Indians have lost their jobs and approximately 97% of households' incomes have declined since the beginning of the pandemic. The digital divide - or the inability to access education via digital device affected 29 million students in India and this has led to documented instances of students dying by suicide. The data from the National Crime Records Bureau showed that poverty (69%) and unemployment (24%) registered the biggest increase in causes of death by suicide.

Suicide is an urgent social and public health issue that needs to be addressed. In order to decisively make a difference, all of us—funders, civil society, the media, healthcare professionals, the health department, policymakers—need to come together first. This effort cannot fall under the sole purview of the mental health sector as we need to move beyond the provision of mental healthcare services. There is a need for intersectoral engagement and collaboration across the fields of law, social work, health services, education sector, livelihood services, and public policies. Last year, I wrote of the heightened levels of distress, compounded by stressors related to food, livelihood, shelter, safety, and basic survival. In this past year 230 million additional people fell below the national minimum wage poverty line. Multidimensional poverty must be addressed if we are to strengthen public health, mental health, and reduce deaths by suicide.

While the situation is very bleak, we are privileged to have a vast and vibrant network of civil society organisations in India doing excellent work. This was especially visible during the waves of COVID-19. As Indian philanthropists and CSRs we must support grassroots, community-based organisations — who as we saw — are best placed to address ground realities and have deep insights versus national or even state-wide organisations.

MHI relied on 28 such community-based organisations and collectives across 22 states to provide a range of relief and mental health support to marginalised communities. The strength, speed and "efficiency" of this relief came from the power of working with hyperlocal organisations who are embedded in their community. It is critical to support such leadership from community and civil society.

I'm pleased to report that as of June 30th, 2021, MHI works with 20 partners on 22 projects, in 11 languages across 18 states with diverse stakeholders such as communities, institutions, and governments. To sign off on a note of hope - it's been inspiring to see civil society leadership in the face of COVID-19 and I exhort those who can to support community-based organisations- especially those without institutional or foreign funding.

Thank you!

HARSH MARIWALA

Note from the Editor

In late March, 2021, I was excited to read the announcement of the theme for World Mental Health Day – 'Mental Health in an Unequal World'; just two months earlier, our call letter for ReFrame's 2021 issue had asked for essays and articles on 'Structural Determinants of Mental Health', contributions that we hoped would trace some of the structural causes of unequal access, unequal vulnerabilities, and unequal outcomes in mental health. This conversation, always urgent, was – partly due to COVID-19 visibilising stark inequities – now becoming mainstream.

Through this edition, we hope to highlight inequalities in access to mental health services, alongside the lack of adequate funding. However, access is a complex issue: neither primarily biomedically determined, nor simply service-led, as the dominant discourse maintains.
The biomedical focus almost necessitates an individual rather than structural or systemic approach, couching mental health concerns in terms of genetics, personal risk behaviours, and predispositions. However, issues of inequality and access both require us to examine the systemic, structural barriers to psychosocial well-being. Inequality is itself a structural problem that cannot be resolved by individual-based solutions.

The individualist analysis of mental distress compels us to question another common aspect of contemporary mental health practice: its dismissal of all structural determinants of pain, anxiety, mourning, and other psychological experiences. To acknowledge their social construction is not to deny the experiences themselves, but often to discover the origins of such distress in specific structural forces. This ReFrame issue attempts to explore, deconstruct, and deny the illusionary location of distress within private realms that are apparently isolated from social systems such as politics, economy, society, communities, policies, or identity.

In this context, the unfortunate story of Dr Sudhakar Rao serves as a sharp reminder. In last year's note, I wrote about how Dr Rao, a Dalit doctor, was incarcerated in a mental hospital after protesting the shortage of N95 masks for doctors. Dr Rao died in May this year, waiting to be reinstated in his job and hoping for justice from the courts in a case concerning his ill-treatment in the mental hospital. Mental health systems including psychiatry, and legal systems, are among the multiple social institutions which derive power from structural forces such as caste, gender, religion, sexuality, ability, and class, and which maintain that power through conformity – continuing to reproduce and reinforce existing inequalities, unless their inherent power systems are recognised and challenged.

The socio-economic determinants of mental health – the conditions in which people spend their childhoods, working lives, later years – have received attention in academia as well as individual practice, but not in services and policies. Barriers to psychosocial wellness need to be tackled in housing and environmental policies, public and private institutions, workplaces and transport, as these are all sites where mental health-related risks play out – for instance, forced migration, or the status of affirmative action measures. Addressing inequalities is bound to remain a slow and piecemeal undertaking unless we disrupt the silo-isation of mental health, and widen its ambit to include the very forces that shape social and political structures, policies and norms.

Social and structural factors have long been treated as lying outside the purview of mental health – or a task for other sectors. Those of us working in mental health need to approach policy across sectors as an important pathway to reducing inequalities. Is it in the purview of a mental health professional to raise their voice in support of anti-caste struggles? Or attend a climate change protest? This year's theme, "Structural Determinants of Mental Health" suggests that these responses do fall within our purview, and looks at how we may embed, in our work, an awareness and analysis of power structures.

The journal is divided into three sections. "Re-vision", the first, reflects on the psy disciplines: both Pawar and Chatterjee look at embedded biases in the knowledge systems themselves. What measures must be taken to dismantle structural oppression within mental healthcare? Manan writes of mental health in educational spaces, exploring how policy and popular models of school mental health need to take a different approach to school-based mental health programmes.

The "Contexts" section explores how systems of power are reflected in a variety of contexts – from childcare institutions to fisher communities in the backdrop of Special Economic Zones (SEZs) and climate change. Bhuyan writes from a location of disability about ableism in the mental health field; Hussain and Sahoo talk of constraints in the rationing of mental healthcare in Kashmir; Khan and Contractor draw links between mental health and religious discrimination in the workplace.

"Engage", the final section, shares on-ground examples, such as support for victims of violence and trafficking through interactions with legal and economic systems; Kannan writes about psychosocial support for disabled riot victims; therapists at "Dance for Mental Health" write about an embodied systems approach to mental healthcare; while Agarwal and Selvan speak of a culture of embodied activism in mental health.

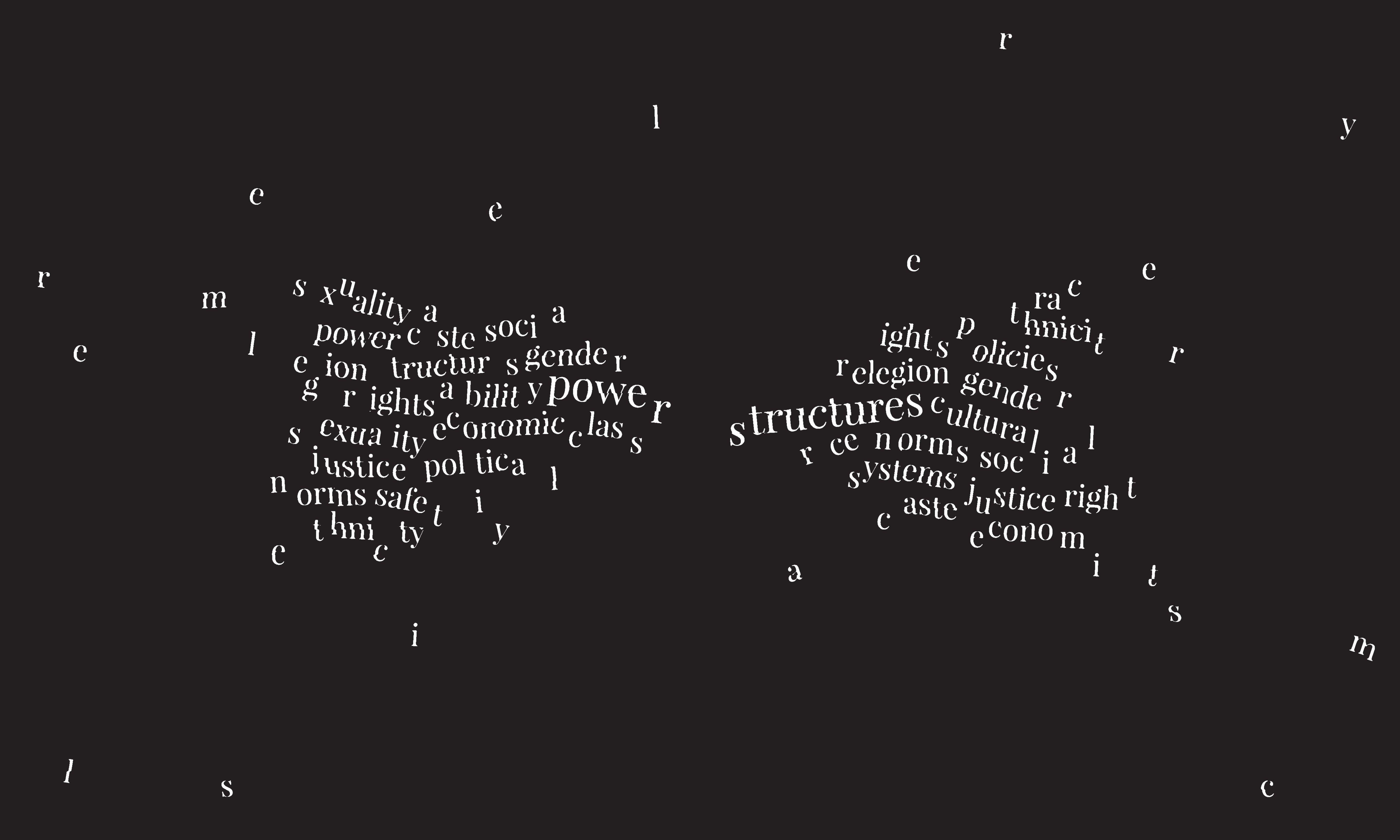
For too long, we have confined ourselves to overly narrow definitions of mental health, applicable only to certain sections. While the user-survivor voice is present in the larger mental health discourse, whose voices are these? Is it mainly those whose identities are structurally at the centre – white, or, in our context, upper caste, Hindu? Cisgender and heterosexual? We know that marginalisations leave individuals uniquely vulnerable to distress – so where are the folx with multiple marginalisations? Where is the intersectionality and allyship with other struggles?

We need to see mental health as an economic, political, cultural, and critically psychosocial process that foregrounds agency and control over life choices; access to education, public transport, public spaces, healthcare, livelihood; and freedom from the devastations caused by violence, poverty, food insecurity, and climate change.

RAJ MARIWALA

Of all the forms of inequality, injustice in health is the most shocking and inhuman. I see no alternative to direct action and creative nonviolence to raise the conscience of the nation.

DR MARTIN LUTHER KING JR



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Unpacking Structural Determinants

Re-vision

Contexts

Engage

We aim to highlight a variety of topics and voices; but will not be able to be exhaustive in our material. The views expressed in ReFrame are those of the contributors and not necessarily those of Mariwala Health Initiative. Articles are accepted in good faith and every effort is made to ensure accuracy.

Re-vision

Framework
Power
Structures
Systems

How do we account for HISTORICAL, POLITICAL and SYSTEMIC FORCES that are causal factors of INEQUITY in mental health? How do STRUCTURAL DETERMINANTS shape experiences of mental health and the potential for redressal or care? What are the ways in which we can ADDRESS these determinants in CLINICAL OR COMMUNITY-BASED mental health frameworks? With EMBEDDED BIASES in KNOWLEDGE SYSTEMS themselves, what are the ways and measures that need to be taken to DISMANTLE structural determinants within mental health care?

Addressing Inequalities: Structural Competency and Collective Action in Mental Health

Dismantling systems of power

BY RAJ MARIWALA, SANIYA RIZWAN

There have been multiple engagements with the dominant bio-medical discourse in mental health, whether it is the need to center psychosocial interventions or to re-conceptualise a treatment gap as a mental health care gap[1] as well as human rights violations, a lack of patient-centered approaches and policy gaps.[2] While the focus on supply-demand issues in mental health services has insidiously rendered the invisibility of mental health as a global challenge and a development issue, the latter's structural underpinnings of social, political and economic identities remain unaddressed. How does this neglected aspect of mental health inequality, its perpetuating causes interact with and evaluate the clarion calls for more and better quality services, data and research as well as increased funding?

The scope of this essay is to understand both; the narratives of mental well-being through the socio-political forces that create them, as well as how larger systems of power impact phenomenological experiences. The structural analysis shared here will further direct the goals of mental health systems and advocacy efforts towards the pursuit of health equities, and subsequently, social justice.

This socio-political lens allows us to situate mental health within people's lives, experiences and contexts. It helps us recognize that marginalized individuals may be disproportionately impacted by mental health concerns,[3] in part due to a greater exposure to stressful events and a lack of social support.[4] Exacerbating this, is the fact that the same mechanism of systemic oppression influences who provides mental health services, who is able to access them, and who these services are designed for. [5] In fact, it is the same oppressive structures that govern public policy and sociocultural norms - be it health, social or economic. And the combination of these factors come together and perpetuate inequalities in mental health.

Thus, it's necessary to ask questions about the gaps in mental health service, data, and funding, as well as those in social safety nets, policies, and laws. Importantly, we also need to study the factors that influence the distribution of social, economic and physical resources, which in turn influence disparities in mental health outcomes.[6] To work toward health, justice, and equity, we must understand how structural determinants are deployed at a population or systems level, community level, clinical level and individual level.

Reframe aims to explore the roots of these determinants lying outside the therapy rooms and randomized control trials - in policies, in public and private institutions such as schools, workplaces, media, families, communities, in social narratives, in mental health advocacy and bigotry of the healthcare systems themselves. Be it youth mental health, suicide prevention or stigma - it is evident that they require multi-sectoral efforts (across government departments, workspaces, educational spaces, media, as well as in communities and families). However, what we need to realise is that the efficacy of such multi-sectoral interventions will depend on how they address the root causes that lie on the axes of caste, gender, class, ability, sexuality and ethnicity.

Can we talk of youth mental health without considering the effects of one's future being decided by solitary competitive exams, or of institutionalized casteism in entrance exams, or of the lack of sexual and reproductive health rights?

The individualist way of analyzing mental distress requires criticism of another aspect of contemporary mental health advocacy: The dismissal of structural backdrops behind pain, anxiety, mourning and other psychological experiences. To acknowledge the social construction of the terminologies of mental distress is not to deny the experience of distress but instead to relocate the origin of it in structural forces such as casteism or cis-heterosexuality. As such, the scope of this Reframe issue is to explore, deconstruct, and deny the illusionary location of distress within a private realm, isolated from social systems such as politics, economy, society, communities, policies, and identity.

Additionally, one has to consider concrete steps to dismantle the ways in which casteism, patriarchy, religious discrimination, and ableism have been institutionalized in healthcare systems themselves. Without addressing the inbuilt discrimination in mental health approaches, curricula and practice, we cannot hope to resolve unequal access to care either.

Systems born of inequalities cannot bring about change
The reforms in psy-disciplines have focused on challenging the legacy of the asylum, profit-making, and pharma. This has led to the assertion of user-survivor voices. However, simply this assertion is not enough because it stops short of dismantling the systems of power that reflect social hierarchy, and built and reinforced the psy-disciplines in the first place.

If we use the lens of systems of power, and of privilege and oppression, it will enable us to contest the definitions and visible narratives of mental health. For example, why is workplace mental health centered around white-collar spaces? And, are persons with visual, locomotor or aural disabilities considered when planning mental health services?

In South Asia - ability, caste, class, ethnicity, gender, sexuality, and religion play a pivotal role in determining the daily stressors, exposures, and susceptibility to mental ill-health. They also inform the options for recourse one can access - in terms of both, mental health support and wider supports such as social safety nets, as well as the quality of care and support received. All major public and social institutions are also entrenched in these forces of oppression and collude to uphold their order in both norms and policy. These oppressions and their consequences therefore interlock, exacerbate, and perpetuate the situation for those who are marginalized, creating a vicious cycle.[7]

Changes in legal and social policy are pivotal in addressing mental health inequalities by mitigating risk and increasing protective factors in multiple contexts - workplaces, education, legal systems etc. While social change is critical towards building health equity - it being a long term process, necessitates policy changes to precede cultural change.

Mapping pathways of health inequalities

SYSTEMS OF POWER

ability
gender
caste
class
ethinicity
religion
sexuality

cultural & social norms

community structures / caste structures / gender norms / caste rules / religious beliefs

health beliefs / social norms / traditions / family structures & decision making / rules around intimate relationships / stereotypes / prejudices / discrimination / exclusion

policies and governance

economic policies and systems / social safety nets / infrastructure / education policy / health systems / labour laws / land laws / housing / affirmitive action / budget allocation / rights based laws / regulations for business

contexts and systems

justice system / state / market forces / climate / public and private services / civil society / organised relegion / economic & work enviroments / media & digital spaces / social service systems / schools, colleges / urban- rural infrastructure / transport systems / diagnostic frameworks of health

risks

civil rights / transport / shelter, home / justice / livelihoods / food / safety / social protection / favourable or "neutral depiction" in media / reproductive and sexual rights / health facilities / public safety / education / safe environment / climate / quality services / digital spaces

individual and interpersonal social capital

negative factors

exposure & experience of violence in obtaining access or use of the above / exposure to "risk factors" such as intimate partner violence / child marriage / unsafe sex / lack of quality or appropriate services / discrimination & social exclusion when trying to access the above

health outcomes

communicable disease / chronic conditions / injury cun-intentions or deliberate / non communicable diseases / maternal mortality / substance dependency / life expactancy / infant mortality / disability / mental illness / health

individual health determinants

exposure to violence / nutrition / water access / sanitation access / income / immunity level / forced migration / childhood adversity / occupation / health behaviours / family and social support / coping mechanisms that are accessible / chronic stress / distress / genetic predisposition / opportunities for physical activity / sexual behaviours / affordability of healthcare / appropriate healthcare

Multi-dimensional Poverty

A 2021 study by Azim Premji University found that 230 million Indians were pushed into poverty after one year of COVID-19[8] leading to widespread unemployment, loss of income, food insecurity and homelessness.[9] Food insecurity is a risk factor for both mental and physical health. Apart from the immediate result of undernutrition, it results in unrelenting distress, anxiety, shame, powerlessness and guilt.[10] Consequently, food deprivation is linked to a higher probability of non-communicable diseases such as diabetes and cardiovascular disease as well as depression and anxiety.[11] This is accompanied with an increase in health care costs and shares a bidirectional relationship with poverty.[12]

Similarly, there are inter linkages between poverty, homelessness, and mental illness. While being homeless places an individual at an increased risk of developing mental illness, there is also an increased risk for becoming homeless due to mental illness. The likelihood of living with mental illness is three times greater for homeless persons as compared to the general population.[13] The psychological dimensions to homelessness - high levels of stress, uncertainty and anxiety - are exacerbated by greater exposure to violence (from individuals and the state), unemployment, lack of access to education and adverse childhood experiences.

Women who are left behind

Using the lens of structural determinants tells us that women who face homelessness are more vulnerable to sexual assault and gender based violence (GBV). Those who experience GBV may experience depression, anxiety, stigma, shame and are at an increased risk for mental health conditions.[14] However, looking along the fault lines of caste, gender and ability, we see that more often than not, trans women, dalit women, adivasi women, sex workers and women with disabilities are not included in the definition of 'women'.

If we unpack some of these examples, we can better understand how multiple marginalizations interact with each other.

Casteism

Take for example, the fact that five out of six multidimensionally poor people in India are from Dalit, Adivasi or Other Backward Class (OBC) families.[15] Further, over one-third of homeless persons are Dalits, showing that the intergenerational cycle of social discrimination and exploitation is profoundly linked to poverty.[16] Unless we use a structural lens, our systems and policies will also miss structural exclusion from social safety nets.

Transmisia

Trans persons living in poverty face unique challenges. A study conducted in urban India and Brazil found that trans women had a lack of employment options and job security. Apart from the stigma of poverty they also faced social isolation due to entrenched prejudice, discrimination, and gendered violence, which then intensified their mental health concerns such as suicidal ideation.[17] Since social safety nets largely require formal identification - they're likely to be inaccessible for trans persons. This is also true for Dalit persons who are homeless - a study found that despite having identification, almost no Dalit persons were able to access benefits such as as subsidized food ration.[18] Thus, for any policy measure against malnutrition, homelessness, or poverty to be effective, the intergenerational cycle of discrimination, exploitation, and exclusion due to caste must be addressed specifically, and must also vary for measures addressing trans issues, and disability rights.

Clearly, individuals from different contexts experience varied dimensions of discrimination - which are linked to posttraumatic stress, depression, and generalized anxiety disorder among other mental health conditions. Such discrimination or perceived discrimation can have a knock on effect leading to limited access to health care, employment, and housing.[19] Here, it is important to also point out that discrimination is embedded in health care systems themselves - whether it is Dalit persons being barred from entering health-care centers, doctors not touching Dalit patients,[20] or LGBTQIA+ persons facing forced pathologization, 'treatment', incarceration, and 'cure'.[21]

Islamophobia

To explain, a cycle of exclusion, protest and violent suppression creates yet another generation of children and adults who internalize their marginalization, accepting discrimination at workplaces, in colleges, or in public spaces inevitable cost to be paid. When islamophobic narratives create dehumanizing policy, violence, microaggression, and deny economic sufficiency, land and social security, the psyche of Indian muslims cannot be explored in isolation. "Self esteem" here, cannot be defined as an individual's appraisal of themselves as if the actual evidence of hate they are receiving in their lives is not contributing to this self perception. "Anxiety" for muslim women arises out of an actual threat of sexual violence they are vulnerable to because of the intersections of patriarchy and islamophobia. When the prerequisites of psychological health are gatekept by structural forces of casteist exclusion, heteronormative and political violence, ableist narratives and capitalist policy, mental health empowerment is to root in the altering of these narratives, change in policy, social relations and livelihood security.

Other than institutionalized discrimination - the above examples also speak to active perpetuation of stigma. However, in mental health stigma is almost exclusively viewed as individual or interpersonal, rather than structural. Based on the above examples, it is clear that we need to approach stigma structurally. This would mean stepping away from 'awareness campaigns' and linear recovery narratives, and working to actively trace the pathways that stigma takes.

> *This also points to the need to challenge stigma as a narrow interpersonal or social phenomenon, and look at it as something that resides in multiple contexts.*

Rethinking research and advocacy

A structural approach would inform which voices of lived experience matter, and would include not only those who have experienced incarceration in a mental health institution, or who have been prescribed medication, but a much wider range of people who have experienced stigma.[22] This also points to the need to challenge stigma as a narrow interpersonal or social phenomenon, and look at it as something that resides in multiple contexts. As Bolster-Foucalt et al outline, stigma exists in "legal frameworks, welfare policies, economic policies, social and built environments, media and marketing, pedagogical factors, health care policies and practices, biomedical technology, diagnostic frameworks and public health interventions.[23]

Using the lens of structural determinants would also affect approaches to research and advocacy in mental health. For example, a research study by Hatzenbuehler et al found in 2004 that LGB adults who lived in areas that banned same-sex marriage experienced significant increases in mood disorders, alcohol dependency, and in generalized anxiety disorders, versus LGB adults who lived in areas without marriage bans.[24] In another study Hatzenbuehler et al found the first state in the USA to pass a same-sex marriage law saw improvements in the health of gay men with significant reductions in depression, hypertension and stress disorders, all within 12 months of the law being passed.[25] This can allow one to posit that affirmative policies addressing structural forms of stigma may improve health indicators, whereas institutional, policy and law based stigma can negatively impact health indicators.

While policy changes may have significant effects, there also need to be commensurate changes within health structures. Despite the repeal of Section 377 in India and the National Legal Services Authority (NALSA) 2012 judgement, structural stigma resides in mental health curricula and in practice both - with LGBTQIA persons being forced to undergo conversion treatments and more.[26] Both psy-disciplines and physical health - are grounded in biological explanations or cultural differences related to health behaviours. Neither of these approaches foreground structural causes that limit and impact individual well-being. Thus, all curricula need to be reformulated for structural competency - recognizing, understanding and addressing the structural determinants that shape patients' health and create health inequities.[27]

Structural Competency

Developing medical or psychiatric expertise has been largely restricted to the biological and cultural lens so as to individualise 'health-related behaviours' such as substance dependency. To provide acceptable and appropriate services to all, it is clear that the services must be affirmative i.e. able to recognize and address the effects of structural oppression that lead to a range of inequalities.[28]

A normal mind follows social expectations for their age and stage of life-development and falls in line with norms premised on beliefs, and social expectations that uphold cis-heteronormativity, religious, caste and race rules.

The "lack of emotional expressions," "the lack of behavioural participation," "the lack of productive labour" are phrases that can be found as symptoms of mental illnesses in diagnostics bibles.

an experience caused when one is denied agency over and acceptance for their gender is termed as a mental disorder.

representing a diverse expression of the human mind, are defined as learning disorders.

However, the psy-disciplines - by virtue of defining what is 'normal' and 'abnormal' - are one of the key pivots for structural oppression around ability and neurotypicality. This difference is politicized when it is unequally catered to, where some minds are normalized while others are pathologized. This occurs through creation of economic policies, political systems, familial norms, and community standards that accommodate and fulfill the needs of few people who then enjoy the power of a socially constructed, exclusionary and rigid notion of "normal mind."

People with mental illnesses and neurodivergence who lie outside this construct are marginalized by this system of neurotypicality. For example, educational curriculums, timelines and deadlines don't cater for the needs of students with autism; and the ambitious glorification of work and hustle dehumanizes people with anxiety, depression, psychosis and other mental illnesses who do not fit the ableist expectations. In addition, mental health campaigns depict linear recovery narratives - thereby upholding neurotypicality as the desired, default, and successful destination to reach. To look structurally at 'illnesses' ' is to also understand and resist the systems that define them as medical 'issues' and the stripping of agency, individualized responsibility and isolation brought by the endowment of pathology.

A "mental disorder" is currently in the vocabulary of deficits. The "lack of emotional expressions," "the lack of behavioural participation," "the lack of productive labour" are phrases that can be found as symptoms of mental illnesses in diagnostics bibles. The deficits are measured against a pre-existing expectation of what is normal and the deviance is hence defined as abnormal. The diagnostic claims made by a psychiatrist are hence, essential ethical judgements regarding the congruence of one's behavioural expression with that of social expectations.[29] This signifies that mental health is not a matter of natural phenomenons but socially constructed taxonomies of illness and recovery.

What are the nuances of such narratives of normalcy, who constructs them and what consequences the labels bring then become important. Hysteria was popularly used as a term to define women who presented themselves differently than the white man's criteria for a normal woman. Gender dysphoria, Autism and ADHD. The pattern implies the construction of "disorders" to be non-conformity of social norms or the inability to function and participate in such a society due to the said norms. Hence at the very basic stage of semantics, mental disorders are often socially constructed

labels for certain experiences, determined by structural forces.

Mental health is political

An integral part of building structural competency is learning from lived realities and centering the knowledge and labour of the margins. This cannot be done without the involvement of persons who are marginalized by structural oppression.

Further, to build structural competency within the psy-disciplines, the complicity of mental health must be acknowledged and subsequently countered with the understanding that responsibilities extend beyond the therapy room or simple service provision. This legacy of structural violence and discrimination in mental health must be challenged in multiple ways.

To paraphrase a report on 'Building Allyship', mental health practitioners or systems must take it upon themselves to provide psychoeducation to multiple stakeholders who hold power - whether it be families or neighbourhoods, courts, educational institutions, media etc.[30]

This must include building a supportive network of structurally competent allied services and practitioners. It is imperative for mental health practitioners to deploy the privilege of their expertise to testify for courts, and for policymakers to push reforms that will affect health equity - whether for welfare benefits, workplace safety or affirmative action policies.

This will also necessitate a commitment to collective politics, communication, allyship and solidarity between mental health and activist movements such as women's rights movements, anti-caste movements, disability rights, labour rights, LGBTQIA+ and black lives matter. We cannot side-step the need to address social, economic and institutional exclusion that contributes to psychosocial distress - which means widening our ambit beyond affirmative mental health policy and services to demand freedom from violence and food insecurity, as well as better provisions of social safety nets, labour rights, lgbtqia+ rights and human rights.

Raj Mariwala is Director, Mariwala Health Initiative and a practising animal behaviourist.

Saniya Rizwan is a final year student majoring in Psychology from Lady Shri Ram College, who spends her days talking, writing and learning politics of mental health, ableism and justice. She aspires to be a psychotherapist, researcher and indulge in the unconscious of power systems and social relations.

ADVOCACY

All the Better to Suffer the Status Quo with, My Dear

Socio-emotional learning (SEL): mental healthcare, or behaviour modification programmes?

BY SAISHA M

In 2018, the Delhi government launched its "happiness curriculum" across several public schools. This is a class taught alongside other core subjects such as Maths, Science, and so on, and comprises three main aspects: mindfulness meditation; stories to promote responsibility; and activities meant to prompt self-reflection by students about their thoughts, emotions, and behaviour.[1] Delhi's Minister for Education remarked that such a curriculum was needed to create 'honest and responsible human beings'.[2] The National Education Policy (NEP), 2020 is explicit about the need to include Socio-Emotional Learning (SEL) in school curricula, while also emphasizing the need for counselling and mental health services in schools.[3] Claims about SEL being the new frontier of school-based mental health laud its efficacy in facilitating long-term academic and career accomplishments.[4]

While the Minister's stated intention may seem valid, aimed at youth well-being, in its very assumption lies the problem: that teaching children to be "honest and responsible", which are already subjective markers, is equivalent to supporting children's mental health and addressing its multifaceted determinants.

the catch-not-all: socio-emotional learning frameworks

The Collaborative for Academic, Social, and Emotional Learning (CASEL) in the USA lists five broad competencies in SEL curriculum: self-awareness, self-management, social awareness, relationship skills, and responsible decision-making.[5] Interpretations of these competencies often yield in-school activities for building empathy, emotional regulation, acquiring perspective, cooperation, how to handle failure positively, and gaining patience. While SEL programmes are often promoted as aiming to create spaces – which are indeed few and far between – for the emotional worlds of children, critics argue that SEL serves, instead, as a behaviour modification programme; that it lacks the critical lens needed for looking at systemic oppressions which are linked to children's emotions, behaviours, and mental health.[6]
The oft-quoted goals and success impact findings of SEL programmes invoke increased attendance in school, better relationships between students and teachers, and the improved academic performance of students "at risk". Helping students achieve obedience, attendance, and academic measures of success are, however, primarily school system-needs that do not necessarily converge with students' overall well-being needs. This raises questions about the ultimate purpose of SEL programmes and their

approach to student mental health. As some scholars have argued:

'Educators . . . must begin by asking themselves about purpose and outcomes: Are we teaching individual students to manage their emotions and behaviors simply for the sake of upward mobility, and therefore continuing to alienate dispossessed and historically subjugated peoples through an erasure of social resistance? Or are we teaching students to recognize and re-claim their emotions and relationships as fuel for political inquiry, radical healing, and social transformation?'[7]

One way to determine whether an SEL programme functions to benefit the school system or its students is to see if students take their learnings from it beyond school – whether they find the skills/learnings meaningful outside school contexts as well. One study found that the relevance of SEL skills outside of school depended not only on the cultural beliefs about emotional expression that students held, but also on their exposure to prejudice, discrimination, violence, and oppression in forms such as racism.[8] For example, some surveyed students spoke of how aggression, which is discouraged in most SEL frameworks, was the only way to support and defend oneself on the streets. This finding illustrates the faulty construction of most present-day SEL frameworks that neither consider family nor community contexts, nor see the structural issues which impact the mental health and emotional world of marginalized children differently than for their privileged peers. For a student facing violence at home, in their community, or even in their walk to and from school, due to their gender expression, or caste, or disability—are classroom-taught recipes for "successful" socio-emotional responses – for happiness, even – likely to serve them well?

While SEL teachers may encounter students only within classroom settings, the general lack of attention towards students' before-school and after-school realities raises concerns about SEL's efficacy in supporting children. Even long-time proponents of SEL movements are lamenting the inherently exclusionary nature of most SEL frameworks and programmes today,[9] and their being limited to the classroom.[10]

the onus: on whom?

To assume that gaining "pro-social skills" is a key method for addressing or preventing systemic adverse experiences which harm children's mental health reflects an understanding that is not only incomplete, but dangerous. It replicates problematic meritocratic messages already found in educational spaces: that an individual's situation (of, say, success or failure) remains primarily, the individual's responsibility. As the scholars quoted earlier put it: 'Even with these well-intentioned efforts to address social and emotional learning, schools will continue to be institutions that . . . place the onus of social and emotional health on the very young people whose social stressors have been shaped because of dispossession and marginalization. This miseducation is hegemonic because it treats students' personal frustrations and social discontent as something that needs to be remedied in them as individuals. In reality, though, the social and emotional health and well-being of . . . multiply-marginalized people [has] much more to do with their alienation from resources born [of] their oppression.'[11] While SEL programmes claim to be inclusive and accessible, the content could itself work – ironically – to exclude: teachers must consider how some students might comfortably carry the socio-emotional learnings beyond the classroom, and how, for others, these might be yet another way to suppress and delegitimize diverse survival needs (such as justifiable anger) into single-dimensional formulae (anger = bad). SEL must guard against training young people to "successfully" suffer the systems that categorically fail them. The "evidence" markers of success through SEL programmes are also due for an unpacking – other evidence-based practices in educational systems, apart from SEL, have also been criticized for their forcible acculturation of groups on the margins, such as Native American communities in the USA.[12]

today in India

The faults within Indian education systems do not end or begin with socio-emotional learning. Firstly, 29% of children in the country – most of whom belong to marginalized communities – do not complete primary education,[13] challenging the assumption that we can equate school-based mental health programs with children's mental health programmes at large. Pandemic-induced lockdowns have only widened the gap and made accessing the right to education more difficult as learning went online and remote. The NEP (2020) has itself been critiqued as jeopardizing many key measures of inclusivity in educational spaces, leaving questions on the continued existence of affirmative measures such as reservation unanswered and removing lessons on constitutional literacy, democracy, and diversity from curricula.[14,15] Neither do education policies in general, nor do SEL frameworks specifically, mention measures to address the deaths by suicide among the country's youth that affect marginalized communities disproportionately.[16] Suicide remains among the leading causes of death for young people under 30 in India.[17] With governments buying into the idea of SEL in schools, trepidation-inducing national education policies, a pandemic which has made structural inequities in all spheres unmistakably clear, and the speed with which SEL is gaining popularity amongst Indian NGOs, it is imperative that MHPs, educators, and allied professionals committed to anti-oppressive mental health work caution against one-size-fits-all behaviour modification programmes marketed as mental health support and also demand changes within the oppressive structures and systems of education.

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LIVED EXPERIENCE

The "Othering" of the Queer Mental Health Professional

Queer dystopias in mental health workplaces

BY ARITRA CHATTERJEE

ILLUSTRATION: ANIRBAN GHOSH

This article attempts to encapsulate the plight of mental health providers/ trainees who come from marginal gender/sexuality locations and their experiences with workplace, and organizational environments. While carrying out these observations, it is important to remember the potential costs of disclosure of the gender-sexual minority identities of the individuals concerned, given the oppressive history of mental health institutions in routinely pathologizing these identities.

queer professionals/trainees in mental health ecologies

In addressing structural inequities in mental healthcare, what most readily comes to mind is their likely impact on the service users/ recipients of care. The way in which such inequities get played out in the organizational climates of mental health workplaces and educational institutions seldom engages our attention.

Mental healthcare ecologies seem to be complicit in perpetuating the notion of a barrier-free utopia when it comes to workplace and institutional environments, drawing on grand professional virtues such as value-neutrality, a non-judgmental outlook, inclusivity, and diversity. By extension, these popular assumptions sanctify the image of mental health personnel, absolving it of structural biases – and, as a natural corollary, their interactions with colleagues and supporting staff are assumed to be similarly flawless. Quite often, however, another picture emerges when we listen to the margins.

locating "coming out" in mental health workplaces

The author would like to evoke a historical moment of disclosure in the history of the mental health workplace. Before homosexuality was voted out of the Diagnostic and Statistical Manual of Mental Disorders by the APA's Board of Trustees in 1973, gay rights activists Frank Kameny and Barbara Grittings held a panel at a Dallas convention of the APA with John Fryer, a gay psychiatrist appearing under the pseudonym of Dr H Anonymous. Fryer felt obliged to disguise his identity, given the realistic fear of adverse professional consequences.[1] He made a masked appearance in a wig, declaring with sheer grit over a voice-changing microphone: 'I am a homosexual. I am a psychiatrist.'[2] Fryer disclosed that 200 other gay psychiatrists were present at the convention, and also revealed the existence of a gay psychiatrist association. This subversive moment in history tore down the assumed cis-heterosexual location of the mental health professional, and blurred the divide between the "curer" and the "to-be-cured". As Grittings later recounted: 'It opened up things a great deal, because it made many psychiatrists realize gays were not some abstract

idea, but were in fact [present] in their profession.' In retrospect, it is necessary to note that Fryer was subsequently terminated from psychiatric residency at the School of Medicine, University of Pennsylvania.

sampling experiences from the Indian context

In a quantitative study[3] that focused on unpacking attitudes towards homosexuality among psychiatrists of India, it was observed that most psychiatrists (83.5%) were comfortable referring their clients to a homosexual colleague. Even so, some still had reservations about exposing children to homosexual professionals.

Kottai[4] narrates his experiences of 'exclusion' and 'everyday terror' as a clinical psychology trainee in Tezpur, Assam, where his gender/sexuality became a point of contention and ridicule amongst the institutional fraternity:
'There was immense scrutiny and control on the way I talked, dressed, emoted and behaved in the mental health institution.... A senior psychiatry student eager to probe my sexual preferences constantly quizzed me on the hostel's public spaces, blatantly violating my fundamental right to privacy. The academic space was [so] bruising and intimidating that even the junior students used to mock me by [mimicking] my tone of voice and speech.'

Prasad[5] shares their experience as a queer individual in India learning about LGBTQIA+ issues within a psychology classroom, where information about extremely private aspects of queer sexuality was disseminated without regard to whether the receivers had the sensitivity to be given these graphic, albeit factual, details:

'...the next hour was only about the different roles that queer people play in the bedroom, with specific descriptions of their acts.'

structural and environmental barriers in organizations

According to a study[6] that focused on LGBT healthcare trainees' and professionals' perspectives on academic careers in a Western context, some of the prominent barriers were: a) institutionalized bias against LGBT scholarship, often coupled with uncertainties around promotion due to such academic engagements; b) lack of access to adequate mentorship and networking opportunities; and c) hostile climates within institutions. The study included social workers and behavioural counsellors under the rubric of healthcare trainees/professionals, and is therefore quite significant in our present context. 12 LGBT-identified trainee counsellors were interviewed about the everyday slights and insults they encountered in their programmes on an everyday basis.[7] Participants, who were particularly upset to encounter such behaviour within a setting committed to well-being, had a sense of professional disillusionment, which was further compounded by the lack of adequate faculty intervention.
With reference to the training ecology of mental health professionals, a queer therapist[8] based in India observes that cis-heteronormative bias cuts across such ecologies universally – they claim that while professionals are urged to be open-minded and sensitive towards gender and sexual minorities, sensitivity training and in-depth learning about gender-sexuality are missing.
Voices of dissent become submerged in mainstream Psy discourses as a result of power asymmetries. In fact, the Indian Psychiatric Society and the Indian Association of Clinical Psychologists practiced silence on LGBTQIA+ issues until the active involvement of courts.[9] The IPS position statement on homosexuality as being a natural variant of human sexuality came only in 2018, in the same year that the country's apex court decriminalized consensual same-sex relationships, although de-pathologization of homosexuality had long been a matter of clinical consensus. It was only in 2020 that the IPS and IACP spoke up about the harmful effects of conversion therapies on gender and sexual minorities, following a rights-based furore over the death by suicide of 21-year-old Anjana Harish, who had been forcibly institutionalized by her family for "conversion treatment" for her bisexuality.[10]

> *...while professionals are urged to be open-minded and sensitive towards gender and sexual minorities, sensitivity training and in-depth learning about gender-sexuality are missing.*

drawing the strings together

It is interesting to note how, in an article[11] outlining the role of the psychiatrist with respect to the lesbian, gay, bisexual and transgender population of India, the psychiatrist's "being" is constructed, throughout, as exclusive of LGBT+ status.
As far as the author is aware, none of the professional bodies in the arena of Indian mental health is explicitly vocal about the possible intersection between GSM (gender and sexual minorities) status and mental health professional identity, thereby invisibilizing and completely erasing a range of significant voices from the discourse.

Given the timeline of developments in queer mental health in India, and the perennial bracketing of the queer person solely as a potential client, it seems implausible at the moment that mainstream Psy discourse in India will warm up to acknowledging the contribution of the lived experiences of queer mental health professionals, or work towards building safe workspaces for them. The journey ahead seems long and tedious, with resilience and self-affirmation as the chief coping tools for professional survival. Networking among queer-identified professionals/trainees could aid in the amplification of their voices so as to create ripples within dominant Psy discourses through brave advocacy.

'My silences had not protected me. Your silence will not protect you.' – Audre Lorde

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LIVED EXPERIENCE

Freeing Today's Class(room) from Caste

BY RAJESH PAWAR

Looking at how caste hierarchies and norms in educational spaces affect mental health knowledge production, which must consciously reject the old oppressive frameworks in order to play an emancipatory role

exclusions in institutional spaces

It is generally believed that educational institutes are a major site for the teaching, learning, and practice of liberal ideas and behaviour. These institutes are also symbols of pride, seen as places of knowledge production. Contrary to this spirit, however, is their other side, where they become spaces of injury to liberal ideas, rarely offer constitutional space for students– and plead ignorance or pretend innocence on both counts.

It was as a student that I realized how the whole structure of discussion in the classroom invariably favours the more privileged students. When many students and teachers drew upon certain common experiences with which some persons present were not familiar, the whole exercise would become one that reflected the realities of "upper" caste people alone. For example, when I was studying Psychology, the questions and discussions around happiness focused on upper caste activities and values like having dinner at a fancy hotel or, if someone wanted to describe their interests, they would use phrases like "foodie, moody" – reflecting an upper caste societal tendency to self-identify in consumerist terms. Besides this, programmes for mental health awareness at the university level were designed using role-play situations for four or more students playing characters with upper class lifestyles, with situations and stories of other class or caste groups totally absent.

Despite it being common knowledge that the Indian subcontinent has multiple communities and identities, and that people from each have their own unique sets of experiences which they themselves know best, most contemporary intellectual frameworks remain confined to a narrow set of nearly exclusive values and stances, marked by a lack of honesty when it comes to acknowledging that most of us exist in cultures broadly defined by caste. Being unable to relate to the elite experiences and values that prevail in the classroom, students from "lower"

The process of producing knowledge without a critical consciousness of caste hierarchy – including within the educational institute – becomes an instrument of exploitation by creating a market of elitist myths about knowledge itself.

caste cultures suffer from a divided sense of self. Fanon, who applied a colonial lens to psychoanalysis to discuss the impact of race and race relations on the unconscious minds of both black and white people, described such self-rejection as being accompanied by painful feelings of abandonment and of exclusion.[1] His psychoanalytical explanations could well be used to explore caste as a historical and constant construct/ context in the minds of the Indian people.

caste "neutrality" in psychology

To be critical of an upper caste bias in Psychology education, is to invite the "neutrality" justification, which claims that being neutral means being objective and scientific. Upper caste individuals who may identify closely with their caste locations often perceive themselves as living by exemplary moral standards; people in the classroom who experience some tension with their caste location and challenge dominant caste norms or strictures are often seen as deviant, as threats to the upper caste identity – and by extension, to authority, which then "deals" with the "deviance" to reduce the "threat".[2] As Foucault notes, an educational system is a political means of 'maintaining or modifying the appropriation of discourse with the knowledge and powers it carries'.[3] There is little question that caste and class are still the major determinants of power in Indian society. The widely accepted Brahminical belief is that high caste individuals possess qualities related to wisdom, intelligence, honesty, austerity, and morality, while lower caste individuals are characterized by dullness, stupidity, immorality, impurity, and so on.[4] Social reformer Jyotiba Phule argued that sacred texts were weapons for maintaining Brahminical traditions; and were considered as divine authorities, giving sanction to the varna system. Even today, educational institutes, through their lack of caste-culture awareness, continue to weaponize texts in the same manner. The process of producing knowledge without a critical consciousness of caste hierarchy – including within the educational institute – becomes an instrument of exploitation by creating a market of elitist myths about knowledge itself. The majority of educational institutes are, in this manner, complicit in the transmission of dominant ideologies in the classroom.

The field of psychiatry, too, is mainly in the hands of the dominant castes, and tends to label the psychic impact of oppressive experiences as the fault of individual over-sensitivity, or as irrational responses on their part, while neglecting the social hierarchies that create inequities through economic power relations and cause feelings of inferiority. Here the individual's suffering becomes an "objective" point, placed outside of its caste-culture context.

freeing mental health knowledge from caste

Empathy could have been, and can be, key to the acknowledging of caste oppression. With identities better foregrounded in their knowledge systems, educational spaces could create more humanizing ideologies. Students might then have the opportunity to exchange experiences and beliefs across identity locations, in a situation where each one nurtures everyone. Rather than teaching how to "fix" others based on ignorance of their lived realities, psychology education could, in this way, become more inclusive and grounded. Empathy cannot, however, be fostered and sustained without a philosophical framework based on freedom and equality. Unfortunately, empathy is often the first casualty of the competitive environment that the educational system encourages, further marginalizing already marginalized students.

Mental health may be seen as an elite discipline, because access to its services and resources remains available mainly to the upper caste population. The deeply rooted caste hierarchies in Indian society make for a rejection of the mental health issues of people from the lower castes by subjugating them and degrading their value as individuals. Their experiences remain absent from textbooks, which intensifies their overall rejection. Meanwhile the standards of "normality" set for personality and behaviour are derived from the realities of particular caste and class sections – and this cannot be seen as "innocent" knowledge production, especially considering how crucially it informs our perceptions of one another. Mental health frameworks exacerbate existing oppressions when they fail to apply principles of social justice while engaging with individuals.

Ultimately, if knowledge is to play an emancipatory and ethical role, it must eschew its brahminical discourse – and this is true of current mental health knowledge power as well. The idea of mental health must be revised to include the liberation of the individual from social ills, which may be seen as a collective political and reformative task.

Historically, Phule's knowledge creation was in contrast to elitist theory and Brahminical traditions. He laid emphasis on knowledge as a tool for shudras and ati-shudras to stand forth and think on their own.[5] For him, gaining a place in the existing discourse doesn't come easily, but involves socio-political struggle. It is through such struggles that humans become active and responsible participants in gaining their self-identity.

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Context

Access
Communities
Justice
Lived Realities

STRUCTURAL DETERMINANTS in our contexts lie on the axes of CASTE, GENDER, CLASS, ABILITY, SEXUALITY - but, how are these forces deployed in varied COMMUNITIES and what are the impacts of these structures? How do we think about structural determinants as not only SHAPING the point of a CLINICAL ENCOUNTER but also understanding that distress is shaped by structural factors much before such encounters, as well as after? How would such factors inform not just future INTERVENTIONS but also ADVOCACY?

ILLUSTRATION: IBRAHIM RAYINTAKATH

RESEARCH

Being Muslim at the Workplace: Implications for Mental Health[1]

The structural violence that Indian Muslims experience, as a significant area of inquiry

BY SANA CONTRACTOR, SABAH KHAN, & PARCHAM COLLECTIVE

introduction

A holistic approach towards health and well-being situates the latter not just in individual circumstances, but also in structural factors that are often overlooked. Muslim citizens in India have been living in an atmosphere filled with both acts and threats of outright violence against them — one in which they are continually vilified and are being threatened with loss of their citizenship. Meanwhile, historic oppression contributes its own unique stressors in the form of economic, employment, and health-related difficulties. The relationship between mental health, employment, and religion-based discrimination is complex and dynamic: while unemployment and labour insecurity are mental health concerns, workplace harassment can cause employees severe mental distress. In 2019-20, Parcham conducted a qualitative study based on 10 in-depth interviews with Muslim youth in two large metros, Mumbai and Delhi, to understand how participants experienced the formal workplace. We draw here on this study, and on our experiences of working with Muslim youth in Mumbra (Thane district, Maharashtra).

lack of access to formal employment

As per the Sachar Committee Report (2006)[1] , a mere 3.4% of Muslims were graduates; less than 8% of Muslim workers in urban areas were employed in the formal sector as compared to the national average of 21%; only about 27% of Muslim workers in urban areas had regular work. As per the report, the low representation of Muslims and the perception of discrimination in securing salaried jobs make them attach less importance to formal 'secular' education in comparison to other groups. The Post-Sachar Evaluation Committee Report (2014) found that a high proportion of educated urban Muslim youth reported being unemployed, tracing differences in the rates (between Muslims and other groups) to social and economic discrimination.[2]
Our own work with Muslim youth in Mumbra reveals a sense of disillusionment and distrust of the state, and of the "other" who *will* discriminate. Respondents pointed out that hiring is extremely nepotistic. First generation graduates, whose

Workplaces function within the larger, entrenched political and social structures, which thus shape the workplace experiences of people from different social locations.

families had no connections in the formal sector, uploaded their resumes on job placement sites and appeared for multiple interviews in vain. Interviews were marked by some form of discrimination, overt or subtle – such as stigma against hijabis, who were asked to let go of the hijab. Interviewers who were Muslim themselves perhaps did not want to seem "regressive" by hiring a woman in hijab.

One person recounted being hired because her name was "ambiguous", only to learn on joining that the firm did not hire Muslims. Our respondents were usually the first and only Muslim employees in their workplaces. One respondent, who also represented the Association of Muslim Professionals, validated this experience – at the job fairs they conducted, they observed that companies were comfortable hiring Muslims or Dalits at lower positions, but not at managerial or higher positions.

bias and discrimination at work

Workplaces function within the larger, entrenched political and social structures, which thus shape the workplace-experiences of people from different social locations. Respondents narrated incidents that made them feel othered – and although only 2 of the 10 described these as "discrimination", all agreed that as Muslims, they had to be extra careful, work harder, and challenge stereotypes. The burden of "making a good impression" was always present. Shorter working days during Ramzan, or being given time out for Friday prayers were, for most, "privileges" not to be "misused". One individual related what was said when a Muslim colleague disappeared with the office laptop: 'If a person leaves with a laptop and disappears for two weeks, people [talk of] "who (name), where … (locality), which community"… the next Muslim who comes in has to work ten times harder to change that stereotype.'

People also spoke of how some (stated and unstated) office policies other Muslim employees, such as not recognizing Eid as a holiday, stigma around food, and so on.

Political discussions in workplaces often caused great discomfort, as these painted Muslims as Pakistanis, terrorists and troublemakers. When Ajmal Kasab was to be hanged, a colleague mocked a respondent, saying, 'You must be very sad today,' – as if, as a Muslim, she must be a sympathizer. Another respondent was sent a WhatsApp forward blaming Muslims for the spread of COVID-19, during the Islamophobic coverage of the Tablighi Jamaat meeting in Delhi.

coping with discrimination

Our respondents reported feelings of anger, humiliation, dejection, as well as physical illness, as reactions to workplace discrimination. One person spoke of how, when a co-worker asked her to explain the actions of Tablighi Jamaat, she retorted, 'Am I their spokesperson? How should I know?' Most however, preferred avoiding confrontation, and tried not to "wear your religion on your sleeve". To avoid triggering conversations around election results, a respondent took the day off. Another felt so humiliated about having to keep watching what she ate that she quit the job.

Implicit in the study was the immense fear that Muslim youth live with. While recruiting participants for the study, oftentimes they would initially indicate a willingness to participate, but later express reluctance, and withdraw. What does it mean to live with this fear of the very real consequences that might follow an honest articulation of the "Muslim experience"?

moving forward

These insights are revealing, but far from exhaustive. Our sample, which comprised mainly urban, English-speaking, upper caste Muslims, does not represent the experience of Muslims marginalized by caste and class, or those working in the informal sector with its gross financial insecurity, lack of protections, long hours, and immense tedium.

Anti-discrimination laws that provide an avenue for raising grievances are clearly needed. However, given the reluctance to speak freely that we sensed among our study participants and fear of backlash, or of jeopardizing future career prospects, such laws would not suffice to address structural workplace harassment. Clear positions taken by management upholding a culture of diversity and inclusion could comfort "othered" employees. The experience of Idris (name changed) is a case in point: one Friday, Idris came to his new workplace dressed in kurta-pyjama and topi. A co-worker's comment on his attire pushed Idris to wear formals the following Friday. His seniors noticed, and on learning of the reasons for the change of outfit, reassured him that they had no problem with what he might wear. Such gestures help employees feel at ease and reduce stress. A systemic shift in work culture is indicated, rather than legal remedies alone.

conclusion

We began this study to try and unpack what "religious discrimination" might mean at the workplace. While not specifically considering mental health, we did gain insights into the complex pathways along which the relationship between employment, religious discrimination, and mental health could be explored. The site of necessary action must be wider than just the workplace. Several questions arise: What kind of pressures does a first-generation learner from a marginalized community face? What kinds of investments have they made and how does not finding employment impact mental health? What does it mean to face multiple rejections owing to your name or your address? What does it mean to self-censor your opinions and suppress a part of your identity when you do get a job?

If a preventive approach is to be adopted, mental health advocates must address the root causes of the alienation and insecurity that Muslims face in various sectors, including employment.

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LAW AND POLICY

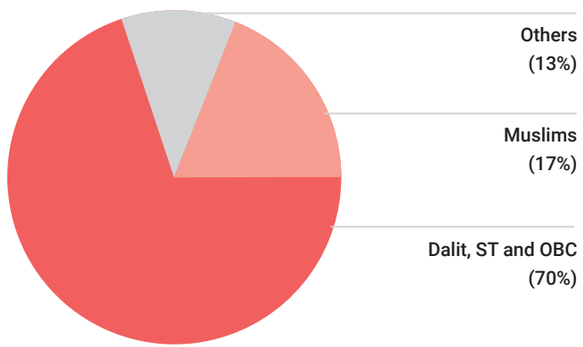
Children in Child-Care Institutions: The adverse impact of marginalization and institutionalization on children's mental health

Marginalized children, being at greater risk of adverse mental health, are more likely to be institutionalized. This article explores ways of mitigating the further harm caused by institutionalization

BY ARTI MOHAN

over-representation in the juvenile justice system

Across the world, marginalized populations including children are systematically over-represented in the legal system.[1,2] In India, marginalized communities account for a disproportionate percentage of the population inside adult prisons.[3,4] Dalit, ST and OBC individuals comprise 70% of adult prisoners, while Muslims comprise another 17%,[5] both figures being higher than their percentages in the general population.[6]



total adult prisoners in India

The same holds true for the juvenile justice system in India. In Counsel to Secure Justice's (CSJ's)[7] experience of working in Child Care Institutions[8] in Delhi and Rajasthan, a high proportion of the children are found to be Muslim and Dalit.[9]

a biased legal system

This over-representation is attributable to structural risk factors: rampant inequalities; and a retributive state that is frequently biased against the marginalized,[10] as the significantly higher rates of arrest, illegal detentions, and coerced false confessions show[11] – as well as more frequent denial of bail due to a lack of the resources needed for legal representation and bail bonds.[12]

marginalization as a causal factor

Not only are marginalized children likelier to enter the legal system due to its inherent biases, their marginalization also predisposes them to mental health difficulties,[13] which may cause behaviours that bring them within the law's purview. Having to cope with high levels of discrimination,[14] microaggressions,[15] feelings of insignificance and isolation,[16] and being deprived of civil, economic, social, and cultural rights, [17] are all factors in mental distress. Being resource-poor, marginalized populations typically lack access to mental health care and support, which further compounds their struggles.[18] Studies elsewhere show that up to 80% of youth in custody have mental health difficulties.[19] What is seen as an individual's wrongdoing may often be a culmination of mental health struggles caused by marginalization.

institutionalization further impacts mental health

Given the isolation and violence they experience, often accompanied by a lack of access to education and health care, many children in institutions develop long-term mental health difficulties including depression, anxiety, and suicidal ideation.[20] Those already marginalized by virtue of their socio-economic class, lack of access to education, caste, religion, or gender tend to be the most vulnerable – often at the receiving end of further violence within the institution, despite protective legal principles and safeguards. 14-year-old Nagesh[21]— one such boy with individual and social vulnerabilities— was subjected to repeated violence by the staff and older children; he began experiencing severe suicidal ideation, culminating in a suicide attempt.

The marginalized tend to be treated as "lesser beings" within institutions, including being subject to caste- and religion-based slurs, often denied the freedom to practice their own faiths or forced to participate in majority religious practices, as well as having to perform caste-based labour – explicitly allowed in many adult prisons until very recently.[22] CSJ's experience shows that children from privileged backgrounds are offered several relaxations in terms of labour (cleaning, sweeping, cooking) inside institutions, while marginalized children may be denied access even to basic facilities.[23] 12-year-old Bipin,[24] who came from an economically

What is seen as an individual's wrongdoing may often be a culmination of mental health struggles caused by marginalization.

deprived background and had health difficulties, did not receive prompt care while in the institution, which caused him aggravated anxiety. Such identity-based discrimination is bound to intensify mental health challenges for individuals.

Family members often do not have the resources to visit these marginalized, institutionalized children, which only deepens the latter's sense of isolation. For most children, mental health difficulties that arise or become exacerbated while in the institution continue to persist post-release. CSJ has worked with many children who had continued to experience extreme mental anguish, including the loss of motivation, everyday coping troubles, incessant crying, fear, loneliness, and sadness. This continuing, adverse impact on mental health has a ripple effect: an increased likelihood of having to return to a custodial institution;[25] dropping out of school; being prone to illnesses; being subjected to physical and sexual abuse; and dying by suicide.[26]

mitigating the harm caused by institutionalization

While broader social and structural change towards a more equitable society is the most essential, including reforms in the legal system that dismantle biases towards the marginalized, other interventions can point the way.

reducing reliance on institutionalization for children in conflict with the law can be a core strategy for decreasing harm. Indian law, as well as various international instruments, endorse the principle of institutionalization as a measure of last resort, i.e., children should be placed in institutions only if doing so is in the best interests of the child, and when no other solution is viable.[27], [28] For instance, when a child is in clear physical danger, or when there is no family member to ensure they stop engaging in harmful behaviours. However, CSJ has witnessed numerous children being sent to institutions for extended periods, and denied bail, contrary to their best interests.[29] Stronger implementation of the "last resort" principle would be an effective first step.[30]

reimagining and broadening our perceptions of accountability would also help to go beyond the institutionalization option. The restorative justice process is an example of such a reimagining. Diversionary restorative justice programs (that "divert" the child out of the legal system) are designed to provide space for the child to be accountable, while counteracting the adverse effects of institutionalization, and, in best practice, also addressing the vulnerabilities arising from marginalization.[31]

interventions within institutions: restorative circles

It is imperative, simultaneously, to introduce reforms within institutions that could help minimize the adverse mental health impact for the children who must, of necessity, stay there. One such intervention takes the form of restorative talking circles – non-hierarchical, non-judgmental spaces aimed at building relationships, talking about adverse experiences. These nurturing spaces have helped children to recognize the ways in which they are affected by marginalization and practice coping through the use of specific, empowering tools.[32] The restorative circle creates a safe space for children to cope with the adverse effects of institutionalization (including isolation and shame) by talking about their difficulties and building mutual support.[33] These circles also help to address violence within the institution.[34] While distinct from other therapeutic spaces that also play a pivotal role for children in institutions, restorative circles address a fundamental need – social support within the institution, which plays its own protective role with regard to mental health.[35] In these circles, CSJ creates space to unpack broader structural harm, including harm arising from oppression and marginalization. Further, for children in institutions, facilitated and structured conversations with their family/community of care at the time of release can help mobilize plans to support the child and meet their needs as best as possible, while also seeking to address their initial vulnerabilities by bringing in relevant service providers – for instance, assisting families to access mental health support. These conversations not only help families understand the impact of the child's stay in the institution; they help children to reintegrate into their everyday lives smoothly.

in conclusion

Institutionalization is a structural determinant of adverse mental health, which is often exacerbated by the already high levels of vulnerability of many who come into the institution. Decreasing reliance on institutionalization through exploring alternatives, along with sustained and institution-wide collective interventions of the kind outlined above, can help to mitigate adverse effects, while also responding to the harm caused by marginalization.

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HUMAN RIGHTS

Making the Invisible Visible

The disabled constitute the largest minority in the world. Given the stigma surrounding disability, how do we look at mental healthcare for PWD?

BY GOURI BHUYAN

disability is a social issue, not a physical one

What do we mean by this statement? To begin with, that the predominant narratives of "normalcy" are hegemonically sculpted by the powerful majoritarian groups: upper-middle class; cis-het; able-bodied; neurotypical; and, in the Indian context, Brahmin men. The unidimensional narratives that thus emerge make anything deviating from the dominant sound wrong or abnormal. Not only are such constructions myopic, they put the onus of this "abnormality" on those being excluded, rather than on the systems that exclude them. (If spectacles had not been invented, an enormous section of the world's population would be visually disabled. However, as the socially powerful also need spectacles, visual disability becomes "normal".)

Distinguishing between physical impairment and disability, one scholar asserts that while the former refers to certain embodied limitations, the latter is the consequence of a society devaluing and disempowering those in the former situation, and categorizing their physical states as abnormal.

It becomes important, then, to consider how these ableist narratives of abnormality construct the disabled experience. Besides the more obvious forms of discrimination it perpetuates, an insidious side to ableism is its internalization by persons with disability (PWD).

what does internalized ableism among PWD look like?

Internalized ableism could manifest as lowered self-esteem with regard to one's abilities and body image issues – or shame about one's body. It might also lend itself to overcompensation of sorts, seen in an extreme perfectionism at tasks, and an aversion to help-seeking behaviour, so as to seem worthy of being treated as an equal. Expressing their sexuality is also, often, a particular struggle.

who benefits?

Most forms of discrimination can be traced back to the buttressing of an existing status quo by those in the top echelons of any hierarchy. In the Indian context, religion is often used to legitimize the abnormality-driven concept of disability. The idea that the nature and severity of someone's disability correlates to the karma from their past life, for instance, is used to guilt PWD into acquiescing in the apparent pitifulness of their situation. Once

ILLUSTRATION: KAASHVI KOTHARI

> *The idea that the nature and severity of someone's disability correlates to the karma from their past life, for instance, is used to guilt PWD into acquiescing in the apparent pitifulness of their situation.*

PWD succumb to the belief that they are deserving of their adversities, they are less likely to try to change anything: this keeps them "in their place"; robs them of their ability to build resilience; and also keeps those in power exactly where they are.

The lived experiences of marginalization keep PWD so caught up with the difficulties of functioning in the world as it is structured, that their mental health often takes a backseat. Traversing through life always seeking to belong can leave a person with very little scope or opportunity for meeting other needs.

PWD: why the gap in mental healthcare?

While abnormality-focused literature and lack of access, are the prominent players here, psychology has also played an inadvertent part in the negative view of disability. Developmental psychology is largely responsible for setting and measuring, norms across the lifespan, thus creating and perpetuating ideas of "abnormality" – which work against PWD.

The very division of development into fixed stages is based on an ableist timeline. For instance, an able-bodied 16-year-old in India is expected to have completed school, but admission into school may have been delayed for a PWD, for reasons of stigma or otherwise.

Psychological research in the area of disability has focused primarily on the ill-effects of the shame and loss associated with the "tragedy" of being disabled – rather than on the systems that perpetuate ableism. "Quality of life" research rarely puts aside its ableist conceptions in order to understand how PWDs construct their own narratives in this regard.

The lack of representation of PWD in the social mainstream stems from being invisibilized and seen as inconsequential in the spaces they do occupy. This results in the mainstream having limited exposure to the lived experiences of PWD. Interactions between the able-bodied and PWD, when they do occur, tend to evoke stereotypical responses in the former: pity; discomfort, even fear; or sentimentally finding PWD who manage everyday tasks or display certain talents "inspirational" because expectations of them are so low.

Pity and sympathy are all too common; discomfort or fear often stem from a lack of awareness or exposure – one fears what one does not know – and another's disability is often an uncomfortable reminder of one's own frailty or mortality. Fear also becomes pejorative towards its object; able-bodied individuals commonly have low expectations of what PWD can achieve. Such stereotypes often colour the way able-bodied individuals, including therapists, perceive PWD, and make it that much more challenging for PWD to create positive and robust identities for themselves[1].

A majority of the disabled community resides in rural India. Most have no access to fundamental human rights like education, equality, a life of dignity, and respect, among others. Ableism often denies access to school and higher education, while more inclusive systems of education that follow recommended universal design are still under-funded. The ill-equipped infrastructure of these schools prevents the integration of students with disability, alienating both students with and without disability from the experience of interacting with and understanding one another.

solutions: reframing perspectives

It is necessary for MHPs to rethink their gaze. Unlike the moral or medical models for viewing disability, it is the oppression model that can help unpack the disability experience. Such a model would be based on the assumption that the mental health of PWD is most likely linked to the oppression and stigma they experience. The focus here would be on socio-political factors, with an acknowledgement of the internalized ableism within therapy rooms.

Therapists need to acquaint themselves with the lived experiences of PWD. For instance, when it comes to the families of PWD, the person with disability is usually in a minority of one. Unlike with gender, race, sex, caste, and other such markers, where usually at least one parent belongs to the same minority group, the individual with disability is often the only such person in their family. So they may not have anyone else to look to, and may well feel alienated even within the family. MHPs, then, need to understand the larger psycho-social and socio-political contexts that intersect to culminate in the gap under consideration here; as well as gain familiarity with the variance in disabilities, across spectrums – including, for instance, the differences between the lived experiences of those with congenital and acquired disability.

Mental healthcare settings, too, can be made more accessible for PWD by following the recommendations provided in the extensive literature on universal design.

Moreover, the acute under-representation of the disability community in psychological research, both as participants and researchers, results in ableist and exclusionary psychological interventions and tools. It is important for younger PWD to see themselves represented not only in the material they read, but also among the professionals with whom they interact. Modelling allows for the construction of possibilities: if an adolescent with disability never sees themselves represented a certain way, the default assumption is that it is not possible for them.

The field of mental healthcare must open its doors to employing more PWD as mental healthcare workers. This would be the best way to set an example, and lead with the inclusivity that the arena often claims to champion.

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LIVED EXPERIENCE

Chinta, Tension, Bhoi: Expressions of distress in fishing communities

BY SIDDHARTH CHAKRAVARTY

In writing this, I kept going back to the image of a dinner table at a local restaurant in a small city in West Bengal. My three companions, who span three generations, are from multiple caste, gender and sexuality locations, and the conversation is about depression. We've recently heard that the youngest amongst us is on anti-depressants – they speak about their therapist, their depressive episodes, suicidal ideations, and self-harm. Listening intently are a young person from a local fishing community— an older person from Kolkata— who has spent most of his life working with natural-resource-dependent communities, and I. At some point, the fisher says, 'Amaader gram e keu "depression", ae shobder babohaar korey na, kintu lokera boley, "chinta hocche".' ('In our village no one uses the word "depression", but they do say, "I feel worried".')

This isn't the first time I've encountered such a use of "chinta". Earlier that week, we were in the coastal areas of the state where, in May 2021, Cyclone Yaas had caused vast swathes to be submerged; boats, huts, nets, livelihood spaces had all been swept under surging waters. As the fisher union spoke to members about their livelihood issues, the latter often used the word "chinta", or the furrowed eyebrows of those who didn't spoke to their experience. During my fieldwork on shrimp near the coast, farmers would regularly tell me, 'Shrimp farming is like gambling. We're tense thinking about whether we'll take losses, or make profits'. A fisher who had recently been beaten up by a group of drunken men on the beach while protecting his fishing gear did not want to file an FIR against his attackers because of "bhoi" (fear).

The drivers of such distress, even when specific to a person, often arise from the structural and social location of the individual; and may hint at more collective experiences of distress. For the fishers, it had been two months since the Cyclone, with welfare or compensation measures nowhere in sight. The state either lacked a true awareness of their losses, or had left the scope of the compensations too narrow, making it nearly impossible for them to resume livelihood activity. What the farmers referred to as "tension" was that in engaging in export-oriented shrimp production, their reliance on insecure land tenures, informal credit, and market fluctuations made the outcomes of their investments and efforts unpredictable. And the fisher's "bhoi" emerged from a long history of engaging with the police as agents of the state, and of violence at the hands of locally powerful, landed-caste men. Ultimately, these powers-that-be represent an Indian society that fetishizes coastal areas as spaces of unbridled recreation, pushing fishers out of regions they have inhabited for generations.

Fishing communities cohabit the coast of West Bengal in sync with the sea. The sea is a source of food which, in living memory, has kept communities alive, through

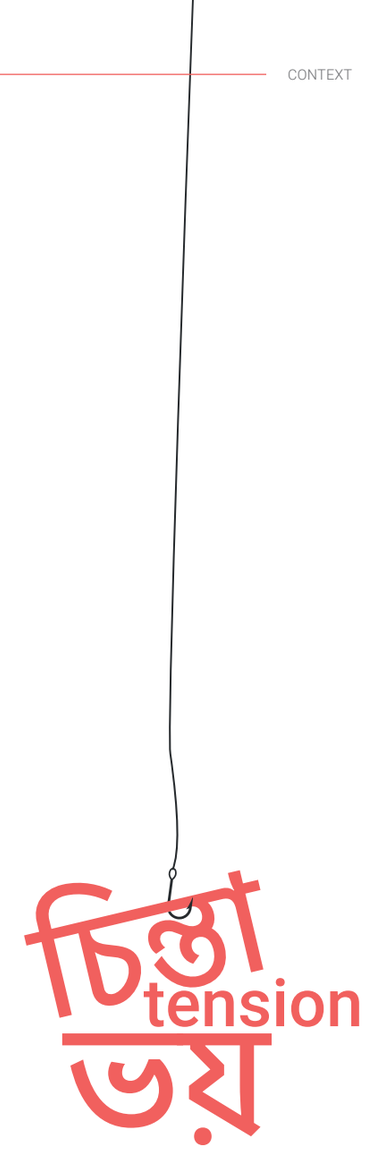
These structural locations not only shape fishers' experiences of mental health, but also their access to medical care.

the Bengal Famine and during subsequent cyclones. The sea describes the geography: villages are well set back from the beach, livelihood and habitation spaces separated as generations of wisdom took account of storms in the region. The sea has topography: adapted to the slope of the seabed and the resulting tidal effects, the "behundi jaal" (fixed-bag net) drives the local dry-fish economy. The sea is seasonal: further north, where the Hooghly meets the Bay of Bengal, the nets change design during the monsoon months to catch ilish (hilsa). The sea is a nursery: along the Pichaboni river's mud-flats, mangroves harbour fish breeding grounds. These forms of connection intimately bind the fishers to the sea – from where livelihoods, identities, and collectives emerge.

Other communities also inhabit the coast: originally, it was farmers who owned parcels of land and cultivated paddy; today it is communities owning shrimp farms, mechanised fishing boats, retail enterprises, resorts, and so on. In the post-Independence decades, fishers were usually either left out of the three-tier governance systems, or were not keen to engage with the process, largely (it is said) because of their seaward-based outlook. The resulting indifference of local governance decisions, from the Village Panchayat level upwards, to the fisher-sea relationship, combined with the absence of fisher representation, often exacerbates their precarious conditions. As capital-intensive processes involving the commodification of land (for cash crops, construction, SEZs) move towards coast and sea under the Blue Economy[1] growth paradigm, fishers find chinta, tension and bhoi that emerge from their isolated location within the larger social structures in which they are embedded.

These structural locations not only shape fishers' experiences of mental health, but also their access to medical care. As I write this, a fisher's nephew is at NIMHANS, Bengaluru. We support them over the phone as they find themselves in an alien city; others accompany them to overcome language barriers. While NIMHANS is a publicly-funded and affordable medical institution, visits from West Bengal end up putting the family in debt each time. The fastest train from Kolkata to Bengaluru is regularly on surge-pricing and is becoming, with the privatisation of the railways, financially unviable. Slower trains make the journey with their child hard, given the heat and crowding. The Covid-19 pandemic further exposes the travellers to severe risk each time, even as the related lockdowns have plunged the already precarious fisher communities into debt. Non-democratic policy changes in state fisheries policies for fishing communities made during this period have further intensified their marginalization, which already has a long history. The climate-crisis has reduced fishing days and fish availability; annual cyclones now regularly disrupt fishing seasons, and inflict an unending cycle of financial losses. Together, these realities reflect both the biopsychosocial drivers and the constraints in accessing medical care that fishing communities experience.

Returning to the restaurant table: the fisher encourages the younger person to visit the beach with him sometime. He says he regularly walks along the beach when he feels overwhelmed. The younger person resists: 'I have depression', they say, 'I need medication and therapy to help me survive'. The fisher ponders this, and says he's never known that form of care, it is new to him; however, walks on the beach help him – he sees the sun rise, feels the sand under his feet, speaks to other fishers, giggles at the auction-site bargaining, embraces the emptiness of the beach at that early hour. And in that moment, 'mon ta halka-halka hoye jaaye' ('the mind becomes lighter'). I take a moment to realize what he is saying: he isn't prescribing a walk on the beach as a cure for depression; instead, his sharing this experience of mental distress from the margins, where he and his people reside, might offer an opportunity to find solace and support. There might be a chance here to explore how mental health in a situation of climate crisis, depleting seas, violent state policies, displacement, caste locations, and gendered lives, is affected and articulated, and how mental distress may be experienced concomitantly with one's structural location in society. On the other hand, in his listening to the younger person, there is perhaps also a nod towards how, until such time as power asymmetries are overcome, there exist avenues of care where chinta, tension and bhoi need not be constant companions.



Siddharth Chakravarty is currently a PhD candidate at Queen Mary University, London, where he researches seafood production in India. He is associated with fishworker unions and collectives across the country. Siddharth is generally interested in seafood, labour, nature and all things that are ocean-based.

Rationing – The Legitimacy Problem in Mental Healthcare: Reflections from Kashmir

BY JITAMANYU SAHOO, MUJTABA HUSSAIN

The rationing of mental healthcare is an outcome of both— the theory of healthcare rationing and its application

The healthcare system in Kashmir has, for decades, been functioning amid political upheavals, persistent violence, and state-imposed curfews. Everyday navigation through the consequently fragile and unstable health system has had an enduring psychological impact on the population. The ongoing COVID-19 pandemic, together with the inaccessibility of healthcare – especially of mental health services – raises pertinent questions around their rationing. This article highlights the role of explicit rationing in managing the mismatch between demand and supply in health services. The allocation of resources for healthcare ends up being one of the more pressing and, often, controversial choices faced by welfare states. The growing pressure on publicly funded services has generated a need to ration them. We attempt to understand the complexities of this allocative decision-making, with reference to Kashmir,[1] where the three-way relationship between rationing, mental healthcare, and human rights has been leading to unbalanced health decisions.[2] The authors also acknowledge the paucity of research in the area, especially in the context of Kashmir, and attempt here to make a contribution in that direction.

understanding healthcare resource rationing

Commonly, "rationing" refers to allocation in fixed quantities, or the provision of a fixed allowance.[3] It connotes a reasonable distribution of resources, carried out fairly and even-handedly.[4] Rationing has been described as 'the allocation of scarce resources among competing ends'.[5] However, while that was the sense emphasized within the domain of economics, other scholars observed and developed three further categories to describe the rationing of healthcare:

first, the allocation of limited resources and the explicit decisions taken for the purpose – such as denial of healthcare services like expert medical opinions, given their expense;

second, that taking into consideration the absolute scarcity of resources, as in the allocation of intensive care beds;

third, rationing determined by the degree of access to treatment, which is linked with ability to pay.[6] These apply to Kashmir, where cumbersome referral pathways to mental health services and the inability to pay for treatment, have been prevalent.

Rationing may, then, be regarded as the apportioning of scarce resources (or distribution of such resources) among those who demand and have access to them. Such an approach has even been justified as being in keeping with ethical principles within health systems, globally, during the ongoing pandemic.[7] However, there is an urgent need to revisit the typology of healthcare rationing and to look at different practices – for instance, at how it is unacceptable in high-income countries but tolerated in low- and middle-income countries.[8]

the necessity and inevitability of rationing

We need to observe rationing from a vantage point that lets us focus on two equations: one, its link to the finite and limited supply of healthcare resources (hospitals, medical staff, medicines); and the other, its connection with the demand for access to care – which is potentially infinite. The mechanism of rationing in healthcare becomes necessary to balance the demand and supply of healthcare resources. For instance, a particular treatment may be denied giving clinical reasons, but the underlining factor would be resource-related. Moreover, the political and popular preference for spending on, and access to, public healthcare is one of the foremost reasons for demand outstripping supply – making rationing necessary to maintain equilibrium. Yet rationing as a core component is largely absent from our policies, despite the increased pressure on budgets and the rising costs of healthcare.[9]

Bhatia explains the two kinds of rationing which are routinely practiced in health systems.[10] In implicit rationing, the imposition of barriers such as referrals to specialists and the use of waitlists, deters healthcare access.[11] Explicit rationing takes into account 'the efficacy and cost of medical treatment, technology, and other interventions that are subsidized by the government.'[12] In resource-constrained societies such as India, without effective checks and balances, access

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through rationing gains significance in situations where affordability is the major determining factor in treatment, notwithstanding the nature of the disease or actual medical needs.
We are driven by health budget totals rather than where and how to allocate available funds. An understanding of rationing could enable better responses to those specifics.

rationing in mental healthcare: observations from Kashmir
The rationing of mental health services has been mainly based on economic principles.[13] The continued contesting of mental and somatic illness when it comes to insurance benefits has created a disease hierarchy, which makes the rationing of mental healthcare visible.[14] And a lower allocation of resources in the 2021-2022 budget to mental health services and treatments has also created an environment of access deficit.[15]

The rise in severity of depression, anxiety and stress,[16] and of suicide rates among the people of Kashmir,[17] can be seen against a backdrop of both logistical and economic lack of access to timely interventions. In addition, mental health resources in Kashmir are largely limited to public-funded institutions – and unregulated private mental health support with varied outcomes. Thus, mental healthcare in Kashmir is distributed across places of care (public and private), severity of mental illness conditions, and demographic sections (mainly youth, women, and children).[18]

An analysis based on field research reflects:

1. An engagement with traditional systems wherein mental illness is understood not as illness but as spiritual deficit and the mental health professional (MHP) is replaced by the local traditional healer. The wide prevalence of this local model is acknowledged, but its effects need further study. Additionally, many people consult other medical professionals instead of going to an MHP, because of the societal stigma associated with mental illness.[19] This makes for a disjointed relationship between access to mental health services on the one hand, and societal stigma on the other, giving rise to efficacy concerns in mental health outcomes. Moreover, the exclusion of mental health conditions from common medical conditions by public health planners in Kashmir is a primary cause of rationing.[20]

2. No resonance with local contexts.
The field of mental health is rapidly growing in Kashmir, with professional interventions done at primary, secondary, and tertiary healthcare facilities.[21] There is a growing concern about uniform mental health interventions being delivered in these facilities instead of evidence-based interventions. There is an urgent need in Kashmir to accommodate local contexts, especially socio-cultural factors, in mental health interventions: inadequate psychosocial education, clinical bias (based on age or gender), and the resulting fragmentation of services needs to cease for effective mental health service delivery. Factoring in local contexts would aid in identifying divergence points and the adoption of different intervention strategies– something that is presently little documented and largely unknown.

3. Engaging with communities.
In Kashmir, we may observe a plethora of awareness programmes, webinars, and outreach activities around mental health every day. The limited availability of mental health services has mobilized community engagement, leading to further community outreach. While capacity building within communities is necessary, professionals in private clinics and hospitals in Kashmir lack rigorous clinical training and clinical experience.[22] Meanwhile, ways must also be found to check the quasi-professionals and non-professionals who are saturating the field and increasingly damaging patient care in the Valley.[23]

With limited resource allocation, a dearth of sustainable mental health services, and no workable alternative mental healthcare models in place, rationing continues to function both at the individual and State level. The authors further note that rationing may therefore be viewed as the conflict between allocation of healthcare resources and the actual decisions that do not always accommodate the choices available.

EDITORIAL NOTE:
With limited resource allocation, a dearth of sustainable mental health services, and no workable alternative mental healthcare models in place, rationing continues to function both at the individual and State level. The authors further note that rationing may therefore be viewed as the conflict between allocation of healthcare resources and the actual decisions that do not always accommodate the choices available.

> *We are driven by health budget totals rather than where and how to allocate available funds.*

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Mujtaba Hussain works as a child rights lawyer at Child Guidance & Well-being Centre, IMHANS, Kashmir. He works on evidence-based legal research on mental health, and directly engages with communities through trainings, advocacy, awareness-building and psychosocial support programmes. He advocates for deinstitutionalisation, or for a community-based model of mental healthcare. Mujtaba previously worked with the National Human Rights Commission, India.

Engage

Implementation
Practices
Psychosocial Factors

This section highlights some IMPLEMENTATION and EXPERIENCES that may serve to challenge the inertia with which structural factors have been treated in biomedical approaches. What is the impact of PUBLIC POLICIES on INEQUALITY and mental health? How do we include structural determinants in the conversation on effective, QUALITY CARE? How can we use the structural lens in our individual and clinical approaches? What ways should this lens be integrated, both when understanding client experiences and making recommendations for FUTURE ACTION?

SERVICE DELIVERY

Centering survivors' short-term and long-term needs

Inside the Criminal Justice System: Foregrounding survivors and victims of serious crimes

BY HAMSINI RAVI

It is well-documented in social science research that structural factors render people from marginalized groups vulnerable to serious crimes such as sexual violence and homicide. Gender-based violence is systemic and pervasive both in India and globally.[1] Most hate crimes stem from the deliberate intention to malign and hurt individuals belonging to certain, usually marginalized, socio-economic groups.[2] Besides being subjected to social exclusions and discrimination, those marginalized by their caste identities, in particular, or living in conflict zones, commonly experience rape, abuse by police and military personnel, land encroachments, and evictions.[3]

Not only are marginalized groups extra vulnerable, their access to justice tends to be limited and is often obstructed.

The National Crimes Records Bureau data for 2019 showed that conviction rates for perpetrators in offences under the SC-ST Atrocities Act were as low as 32% across the country.[4] Survivors, as well as others affected, such as their immediate family and peer networks, tend to be traumatized and re-traumatized by a justice system that colludes with other institutions, such as the police and the medical establishment. Oppressive medico-legal practices in India include the now-banned "two-finger test", where a doctor examines the genitalia of the rape survivor to assess whether they were a virgin at the time of the rape.[5] If prior sexual intercourse is confirmed, this is construed as evidence of "immoral behaviour" on the survivor's part. Apart from the emotional and physical trauma they inflict, such procedures prohibit access to justice, often pushing the survivor into further peril. Caste is a significant marker for studying how the criminal justice system responds to survivors of serious crimes in India. The Vishaka Guidelines for preventing sexual harassment in the workplace were formed in the aftermath of a serious rape crime in 1992. Bhanwari Devi, from an OBC background, was a community worker in the Women's Development Programme implemented by Rajasthan state.[6] Five men raped her because she was reporting instances of child marriage among families from dominant castes like theirs so that government officials could take preventive action. The perpetrators were acquitted by the District Court, with the judge stating that it was impossible in India for members of the same family to commit rape together, or that upper caste men could rape a lower caste woman.[7]

Nearly three decades later, in September 2020, another horrific gangrape was committed in Hathras, Uttar Pradesh. The victim, a 19-year-old Dalit girl, was murdered, and her body secretly cremated by the police without anyone from her family present. The police later claimed that the victim had not been raped at all; it was all a plot to defame the UP Government.[8] The victim's family have since had to face unpleasant court proceedings, with an advocate opining that the four accused, all related to one another, were innocent because 'as per our culture, a man will not rape a woman if his relatives are around'.[9]

Survivors of sexual violence bear the burden of proof of the crime. While women and other marginalized genders have limited access to survivor/victim rights, intersecting marginalizations may further constrain access to these rights. Meanwhile, the criminal justice system in India continues to be focused on punishment, and is known for its delayed convictions as well as for abetting structural forces that criminalize communities marginalized by caste and religion. The death penalty is not uncommon. The law does not address the need for a respectful approach, protection from intimidation, and access to justice mechanisms, legal aid, and psychosocial support.[10] While some laws detail the rights of the accused, there is no corresponding provision for survivors' rights. The UN's Declaration of Basic Principles of Justice for Crimes and Abuse in Power was adopted by India in 1986, but a comprehensive law directing the rights and rehabilitation of all survivors is yet to be drafted.

The criminal justice system in India, having already traumatized the survivor of the crime and those close to them, continues to fail them and invisibilizes their trauma without any kind of structural, financial, legal, or psychosocial aid. Civil society interventions have also tended to be overwhelmingly perpetrator-centric. While there are some important interventions, challenging the justice system's disproportionate persecution of those from marginalized sections, they often fail to address the many difficulties faced by survivors: suffering caused by isolation; political and social pressures on family members to drop charges; the absence of necessary police protection.

Against this reality, DISHA (Developing Intervention for Social Human Action), an Amravati-based organization, centers the needs of survivors of serious crimes and their families. It works with survivors of serious crimes, ensuring psychosocial, legal, and procedural support, including linkages to existing government schemes and entitlements, particularly for those from marginalized communities.

Since its inception in 2008, DISHA has followed a victim-centered approach, studying the rights and entitlements existing in other countries as well as conducting action research on the situation of survivors in Amravati district. Apart from psychosocial support to the survivor and their families, DISHA also provides specific need-based services such as helping with procuring medication and accessing healthcare, school,

and college admissions for victims' and survivors' children, and linking survivors to vocational training opportunities so that they are able to consider employment possibilities. By 2020, DISHA had supported 20,316 individuals[11] in navigating their lives after a serious crime had been committed against them or someone close to them.

DISHA's model involves foregrounding the individual's social location, privileges, and oppressions. The course of the intervention for each survivor/victim is charted accordingly. Survivors deal with multiple pressures after the crime occurs, including harsh legal proceedings – and social stigma, too, for being at the receiving end of certain crimes. Often, they and their families suffer economic and social repercussions such as disruptions in education or work, and the loss of social networks. Survivors from marginalized communities face greater stigma, both in the aftermath of the crime and in their pursuit of justice. Home visits— a significant component of DISHA's intervention mode—aid in understanding the victim's background comprehensively. The organization also runs a dedicated helpline for those seeking information and support, and has integrated support desks in police stations across the district to strengthen the interface with victims at the police level, and provide onsite psychosocial and legal support. The police also refer victims and their families to DISHA.

Based on its years of work with survivors of serious crimes and their families, DISHA was successful in its advocacy with the state government, and used public interest litigation to have Maharashtra implement a Victim Compensation Scheme in 2014. The scheme provides a compensatory sum of Rs 2,00,000 to families of murder victims, and to survivors of acid attacks, or other types of assault resulting in permanent disability. DISHA's unique and comprehensive model works with survivors of violence as well as with public systems such as the police and law, and with communities, to build an ecosystem that is responsive to the needs of survivors/victims, with an emphasis on serving marginalized communities. Its model taps into existing government schemes and provisions to leverage support, while using the findings from its work to advocate for structural reforms. The attempt is to ensure short-term psychosocial support for survivors/victims and their families, as well as long-term dignity and security.

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SERVICE DELIVERY

Mental Healthcare is Incomplete without the Body

Drawing attention to the most proximal, but overlooked, system in mental healthcare: The body

BY ADITI TRIVEDI, DEEPA AVULA & SANJINI KEDIA

introduction

The body – a place where the brain and perhaps the mind reside, is but a rare guest in therapeutic spaces, knocking on the door only lightly when asked, 'Where do you feel that in your body?' When the body is brought up in mental healthcare, it is when something goes "wrong" with its functioning, as a "product" seeking perfection; or as a "token" of diversity and charity. In the battle against the systemic inequalities that perpetuate mental health concerns, the role of the body – as a recipient and as a tool of structural oppression and social marginalization – is invisible, much like the bodies of the oppressed. This article emphasizes that ignoring and overlooking the body is a structural phenomenon within mental healthcare, and highlights its relevance using insights from our way of practicing dance/movement therapy (DMT), called the *embodied systems approach (ESA)*.

bodily oppressions and mental distress

Different systems might use the body as a basis for oppression and violence, with some systems finding structural support for cementing and legitimizing such acts. A glaring example is that of laws that require bathrooms to be made available for only two of the biological sexes, and used according to sex assigned at birth. Other examples (from among many) include: discrimination rooted in a combination of colourism and casteism; public infrastructure that is not accessible to people living with various disabilities; barring entry of menstruating people from religious sites and some physical spaces in homes; an arranged marriage process that prioritizes bodily features; and judgements regarding the "wholeness" of a person based on challenges with conceiving a child, or on their choice not to have one. The body might also be the site where oppression and violence are experienced, in ways that include: normalization of corporal punishment for children; harassment based on sexual orientation, and gender identity and expression; domestic violence in the form of physical and sexual abuse; customs such as expecting a widow to live with a shaved head after the death of her spouse.

With work being a key part of many people's lives, the stigmatization of some professions involving the body can also contribute to mental distress. Sex workers, construction workers, sanitation workers, performing artists, and sportspersons, all integrate body actively into their work, but are placed at different points along a moral hierarchy of professions. Financial stability, access to healthcare, and even dignity/respect extended to a person (all of which could

impact mental health), may depend upon whether these professions are celebrated or condemned.

Other forms of distress directly pertaining to the body, such as chronic pain or illness,[1] eating disorders,[2] health-related anxiety, and health conditions and disabilities that are not externally visible,[3] can affect mental health as well. Even commonly recognized psychological needs in mental health practice today, such as emotional expression/ regulation, processing trauma, or coping with the stress evoked by a productivity-focused culture, all have body-based components.

the body in the Indian mental health field

All people, including healthcare professionals, hold perceptions and beliefs about their own bodies and the bodies of "the other", which create thought-based and non-verbal biases in our clinical practice and personal lives. The various factors at play here may include (but are not limited to) family, religion, caste, body type and ability, sexuality, gender identity and expression, education, class, geography, occupation, and language. It is essential, both in clinical and reflexive practices, for healthcare professionals to explore the intersection of these factors, the systemic baggage that each body bears, and the structural treatment of different bodies.

The body and mental health share a bi-directional relationship. Yet many therapeutic frameworks fail to integrate the two clinically. It is important to acknowledge that body-based practices such as yoga, meditation, and breathwork, do exist and are being consciously integrated into the conceptualization of mental health in India. While psychology, at large, seems to adopt a mind-over-body approach, these practices lean more towards a body-over-mind approach.

The former creates space for verbal rather than experiential processing, whereas the latter focuses primarily on the physical manifestations of mental health needs without necessarily addressing their origins. There is a need for a body-and-mind approach that taps into the vital interplay between them in a more balanced way. For mental health professionals, this means acknowledging and working with genetic influences, psycho-neurophysiological functions,[4] body memory,[5] body language,[6] and movement-based responses and coping skills.[7] Not to include the body in mental healthcare services or training is to dismiss a whole part of a person's being. an embodied systems approach to mental healthcare

> *Other forms of distress directly pertaining to the body, such as chronic pain or illness, eating disorders, health-related anxiety, and health conditions and disabilities that are not externally visible, can affect mental health as well.*

In conversations on factors affecting mental health, the most immediate system available to us – the body – is rarely recognized as a system in itself. Discussions on how the body and its movements appear, experience life, and respond, within various systems, are even rarer. ESA recognizes the body as a system which is as relevant as the others. Alongside the ecological systems framework and relational-cultural therapy, DMT, expressive arts therapy, and psychodynamic theories also serve as cornerstones of ESA. Their integration into the services offered, and the processes that support the functioning of the organization (such as training of clinicians, documentation, terms of employment/internship), is further informed by an intersectional feminist lens, a queer affirmative stance, and trauma-informed and person-centered approaches (see Figure 1).

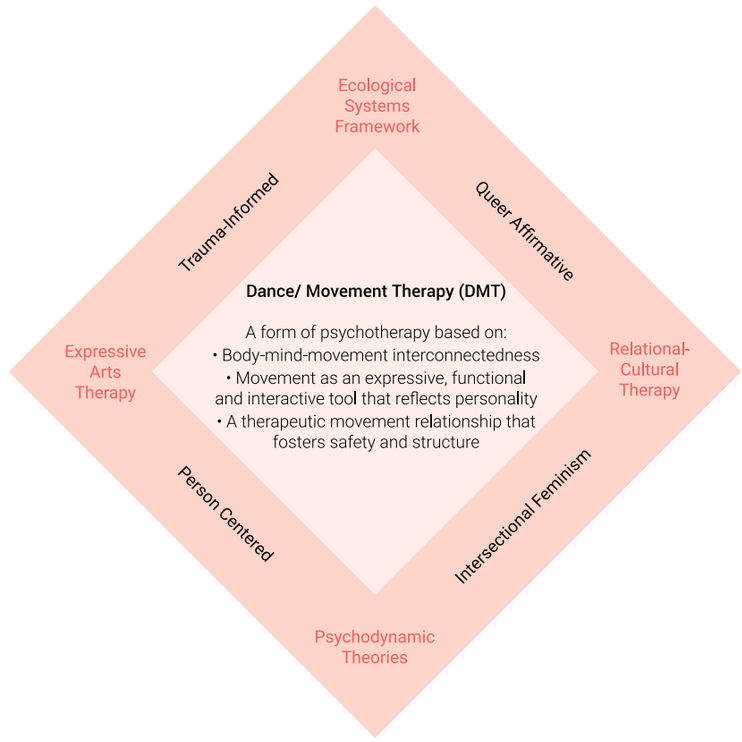

Figure 1

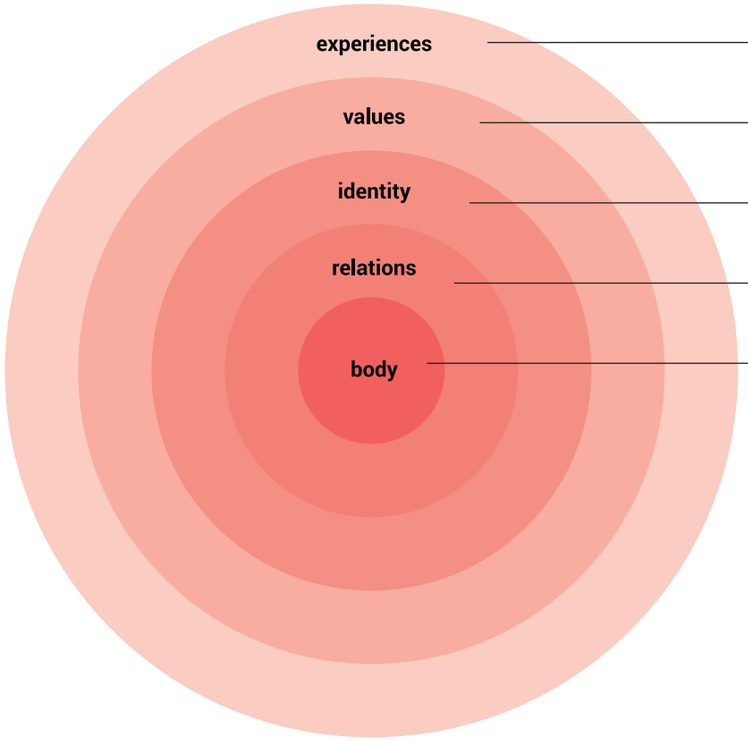

Figure 2

Events, interests and stories we share, forget and reminsce over

Personal/ cultural/ collective beliefs. biases and morals

Self-concept, social groups, power, privilege and oppression

Connection, attachment, safety, security, roles and responsibilities

Senses, emotions, perception, adaptation, regulation, body awareness and image, movement vocabulary and responses

Drawing upon the aspects depicted in the wheel illustrating ESA (see Figure 2), the trained clinician is able to attune themselves to clients and to support them in ways that are congruent with the approach, which allows for an expansion of body-mind awareness, and facilitates shifts in people's relationship with their bodies and mental health. Further, bodies can carry shame, which may present as minimization of posture, gestures, space taken, and so on. When holding and moving shame from an ESA perspective, people can experience body autonomy and vitality in the freedom scaffolded by movement interventions.

ESA in practice: brief examples from therapy sessions

In a therapy session, integration of ESA could present as a couple using their walking styles as a step towards uncovering how expected gender roles in a heterosexual, Hindu marriage in Indian society may be shaped by developmental experiences like co-regulation of emotions, and power dynamics within family-of-origin based on the intersection of gender and age. Another example supports insight into family structure through an intervention: a family attempts to maintain balance while leaning on a circular stretch-band, prompting a conversation on roles within the family – who "provides support", and who "throws the family off-balance". Also, through ESA, when dancing in synchrony with the therapist, a queer client became aware of an asynchronous workplace interaction. The therapist encouraged a further exploration of that interaction, which the client eventually identified as being one of passive body-shaming. In each of these instances, leaving the body or other systems out of the session would have kept significant insights at bay. While only three examples have been given here, our experiences continue to confirm that mental healthcare led from a body-/movement-informed lens alongside a systems lens allows for a somatic awareness, as well as validation of an individual's bio-psycho-socio-relational-cultural experiences. It brings to life the idea that a solely cerebral/ cognitive approach can be restrictive since 'our minds are [just] one thing our body does.'[8]

EDITORIAL NOTE:
The Reframe Editorial team was very saddened to hear that Aditi Trivedi, one of the co-authors of this article passed away in September 2021. We would like to acknowledge Aditi's work as a therapist and as a professional in the dance/ movement therapy space in India. Please do visit her Instagram page @ breathflowmovement on which she has shared her wisdom as a dance/ movement therapist.

Aditi Trivedi (she/ her) was a Registered Dance/ Movement Therapist and Clinical Coordinator at Dance for Mental Health (DMh). She pursued a Master's degree in Dance/ Movement Therapy and Counselling from Drexel University. Her past clinical experiences in the US include working at a school for children with cerebral palsy, at an outpatient family therapy centre and in paediatric, and mental health hospitals.

Deepa Avula (she/her), is a Board-Certified Dance/Movement Therapist and CEO/Founder of Dance for Mental Health (dMh), a Mumbai-based organization providing psychotherapy and psychosocial services using an embodied systems approach. She has a Master's from Lesley University, USA, and offers individual/couples/group therapy to children/adults. She was formerly an Outpatient Clinician in Boston-USA, and a Sukoon Counsellor, TISS.

Sanjini Kedia (she/her) is a researcher and a Registered Dance/Movement Psychotherapist who has a Master's from the University of Roehampton, London. She works as a therapist and research coordinator with Dance for Mental Health (dMh). Sanjini has presented her research at two global conferences, and is a member of the Research Committee of the Indian Association of Dance Movement Therapy.

ADVOCACY

Justice and Recovery: A Forced Binary

The schism between justice and mental healthcare for survivors of trafficking violence in India

BY POMPI BANERJEE

responses to victims of human trafficking

Narratives of survivors consistently show how trafficking is neither a single episode of violence, nor the only form of repeated violence that survivors endure. Kidnapping, abduction, rape, confinement, physical torture, blackmail, threats, and grooming – more than one of these violations tend to be involved, causing poly-victimization. However, the current socio-legal framework in the anti-trafficking ecosystem fails to focus on the impact of poly-victimization on survivors' mental health.

Trauma reported by survivors does not consist only of their direct experiences of exploitation by traffickers, but often includes the deprivations and causes that led to their entrapment by the latter, as well as the treatment they undergo at the hands of both, the criminal justice system, and the social welfare agencies that "rescue" them. A system that seeks to ensure justice for survivors must address these multiple aspects. However, a custodial approach to the rehabilitation and protection of survivors of sex trafficking, and the focus on criminalizing traffickers – without adequately defining and protecting the rights of survivors, or making service providers and policy implementers accountable – results in a skewed approach, and a disabling environment for survivors to recover from trauma. While poorly functioning welfare agencies take over survivors and their rehabilitation, the law courts combine with custodial shelters and poor, non-accountable counselling services to inflict secondary trauma.

the mental health status of survivors

In 2014, 'Bringing It All Back Home', a study[1] on the assimilation of survivors into their home communities, showed that barely 3% of the respondents accessed government support services for their rehabilitation. The study also shed light on a possible reason – the debilitating impact of trauma on their mental health. 87.3% reported symptoms of dysthymia (persistent depressive disorder), while 13% were experiencing major depression. These are alarming figures, especially when compared with the prevalence rate of 1.8% depression and dysthymia for women in the general population. The study hypothesized that the lack of PTSD (Post Traumatic Stress Disorder) assessment and its treatment, not mandated by the law or practised by welfare agencies, results in the condition's remaining unaddressed. Following the 2014 study, Sanjog—a mental health rights organization—tracked the mental health and well-being status of 100 survivors from West Bengal, between 2014 and 2020,[2] while providing them with psychosocial services. This intervention responded to survivor priorities by strengthening access to psychiatric and psychological services in state-run hospitals; through training and supervising a cadre of grassroots social workers in the delivery of trauma-informed restorative care; and mobilizing survivors to form support groups. During a reassessment in 2018,[3] 62% of the respondents reported a reduction in the severity of depression, anxiety, and/or PTSD. For the next six months, the intervention was modified to ensure that the 38% who were still experiencing severe symptoms received psychiatric treatment and counselling or therapy from private clinics. 60% of this latter group reported improved mental health.

In 2019, a study[4] on community-based rehabilitation interventions run by NGOs across 10 states of India for survivors of human trafficking and survivors of sexual and domestic violence showed that trauma-informed mental healthcare remains one of the key challenges faced in all of these programmes, due to the prevailing lack of focused policy, and a lack of resources.

causes affecting mental health of survivors

marginalization of communities

Demographic profiles of survivors of trafficking indicate that 80-90% belong to backward castes, and to religious, political, and economic minority groups; and have, typically, faced at least one of these situations – child marriage, domestic violence, income insecurity, caste-based violence, forced migration or displacement, gender-based violence. Such experiences of violence are further exacerbated by their lack of access to recovery services, or other opportunities to mitigate or minimize the impact on their overall well-being.

There is a dearth of community-focused interventions to prevent violence: While the central and state governments have created welfare schemes for poverty alleviation and economic inclusion, coverage of rural areas is inadequate. Incidents of violence are largely handled using the lens of criminalization. Relying only on punishment for individual perpetrators is, however, ineffective in the absence of a framework that addresses the developmental roots of violence.

Undefined rehabilitation: Presently, India does not have a definition of rehabilitation for trafficked survivors. The dominant notion of rehabilitation – that of restoring the victim to their former state of assumed well-being (their life as it was prior to the crime taking place) – ignores the fact that experiences of poly-victimization cannot be undone by any measure of the law and policy; also, the assumption of prior well-being is deeply flawed. Even a cursory study of the demographic details of victims would reveal that they were rarely "well" – physically, psychologically, socially, economically, or politically.

reintegration without addressing vulnerabilities

Current rehabilitation processes follow a linear trajectory, beginning with rescue, and then institutional care, followed by reintegration. The Freedom Communities study[5] clearly showed that the government systems act only as service providers, rather than as active participants in community-based rehabilitation processes. The trafficked survivors are returned to communities that are now hostile, and that stigmatize them, while the preexisting conditions of violence and vulnerability continue to exist. The added threat of intimidation by their perpetrators further oppresses many survivors.

In the case of labour trafficking survivors without access to welfare services, the vicious cycle of servitude often restarts after reintegration. Consequently, they fall back into the debt traps of contractors and traffickers, in order to sustain self and family.

It is important to note that none of these provisions include focused interventions either at the individual or group level for complex PTSD, or for the assessment of survivors; mental health. Redressal mechanisms for violence and stigma faced by survivors within their communities are also missing. While a legal framework delineating the government's responsibilities towards survivors of trafficking does exist, it fails to be implemented, because managing and driving Community-based Rehabilitation (CBR) programmes demand a commitment that appears to be absent: CBR requires clear planning and protocols, provision of resources, decentralization, referrals, and finally, monitoring and evaluation.[6]

intersectional justice: trauma-informed justice

For such justice to be possible, mental health needs to be recognized and acknowledged as an intersectional issue, and not a medical issue alone. To address the invisibility of mental health as a core component, justice must be redefined to include restorative justice, and not be limited to retributive criminal justice. Significant investment is required to be made by government and non-government stakeholders into building intersectional interventions to address the impact of violence on the mental health of survivors – by foregrounding survivors' own voices.

Pompi Banerjee is a queer affirmative psychologist, policy analyst and researcher working with Sanjog Trust. She is a human rights advocate on mental health,gender and sexuality rights activist. She has worked in the anti-trafficking sector since 2015 with multiple stakeholders, including survivors and NGOs to understand the impact of anti-trafficking laws on survivors and to identify areas of strengthening the anti-trafficking response system in India.

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CAPACITY BUILDING

Creating a Culture of Embodied Activism for Mental Health Professionals

Exploring how we can unlock the wisdom of our bodies to guide and sustain us in bringing advocacy to therapy

BY POOJA AGARWAL, AARATHI SELVAN

As mental health professionals who want to ensure therapeutic spaces are rooted in social justice, we have to contend with various oppressive systemic ideas, policies, and teachings. How, then, do we unpack the Brahmanical, cis-heteronormative, as well as class-, education-, and ability-based privileges that feed into the individualized, internalized framework of mainstream psychology, so as to incorporate more contextual, justice-based lenses in our work? This article attempts to lay out how we, at Pause for Perspective, are navigating these challenges, and to explore how training spaces for MHPs and community workers can inculcate skills to help them discern and unpack structural determinants of mental health, through embodied activism and advocacy.

mindfulness: a collective practice rooted in compassion

We start by attuning our minds to our bodies, to become aware of and make space for the ways in which our bodies are impacted by – and respond to – structural factors. Mindfulness is a practice for cultivating intentional awareness of experiences unfolding within and around us, encouraging curiosity and an openness to leaning into each moment and noticing our sensations, emotions, thoughts. As a clinical, therapeutic modality, mindfulness has become a buzzword in recent times, and (not unlike mainstream psychology) commonly follows a westernized, individualized model. It offers tools for emotional regulation, managing stress, allowing difficult thoughts and feelings to pass. While these are important contributions, we find it essential to recognize that justice and compassion have, historically, been grounding principles of mindfulness practice in India.

Mindfulness has a complex history in the Indian context, originally deriving from the Buddhist tradition of "sati" (awareness), and travelling to the West where it became an evidence-based approach in Psychology. As it makes its way back to India in its psychologized form, it becomes essential to reconcile it with existing traditions of Indian Buddhism –

ILLUSTRATION: KAASHVI KOTHARI

While we see anger and violence in the streets of our country, the real battlefield is inside our bodies.

most notably, Dr BR Ambedkar's interpretation of Buddhism as a practice that can amplify the Dalit movement to annihilate caste and create a compassionate society.[1] Ambedkar founded Navayana, the "New Way", as a sect of modern Indian Buddhism which interpreted "dukkha" (suffering) as a collective, social suffering that was a result of historical marginalization and unequal systems of power.[2] He envisioned "Nirvana", then, as a process of collective and social transformation rather than a purely individual pursuit. We find this framework to be extremely supportive of our own mindfulness practice, in which the experience of "autopilot" – the flight, fight, freeze, and fawn[3,4,5] responses in everyday life – is understood as a result of collective suffering due to that which fractures our body-mind-community relationship, and not simply as an individual, internal experience. Sensations of discomfort, pain, and so on, that show up during mindfulness practice, are seen as the body's response to the world – as sensations that inform us of what is important to us, and not simply to be passed over, or regulated.

By keeping the practice trauma-informed and inclusive, by offering alternatives, and co-creating what mindfulness can look like for each person, we make this an activist practice; we cultivate it not as a way to be better adjusted, but instead to inform ourselves of how our body responds to prevailing systems and conditions, in order to be able to respond in ways that best align with our hopes for our body-mind-community.

embodied activism in training spaces

"While we see anger and violence in the streets of our country, the real battlefield is inside our bodies." —Resmaa Menakem[6]

With increasing research, it's becoming evident that structural determinants like gender, sexuality, class, caste, race have long-term, inter-generational impacts on our bodies: we inherit bodies that store trauma. Our nervous systems are primed to react to others' nervous systems from a place of survival and self-protection rather than connection. Thus, the mere cognitive understanding, or discourse, of systemic oppression and intersectionality is not enough to transform our learnt and habitual responses that maintain the very inequalities from which we wish to break away. Embodying this work allows us to sense how the nervous system expresses the discomfort of our privileges, the ache of our traumas and oppression, and the resulting responses of fight, flight, freeze, and fawn. Leaning into these sensations, along with their associated emotions and thoughts, allows us to embody and express our knowledge in safety; heal with the collective; and heal the collective as well.

We build this approach into our Integrative Mindfulness Based Practices Training (IMBPT) program that introduces formal and informal mindfulness practices. As we learn to notice and stay with sensations and body responses, a range of possibilities becomes accessible to us. The nervous system, slowing down, is able to access cues of safety that enable us to step out of habitual patterns and gain the space to respond in ways that are aligned with our values. Additionally, we become familiar with how our experiences of privilege and oppression show up in sensations of discomfort, heaviness, tightness, and aches. Becoming aware of our sensations allows us to step away from the stories reinforced by dominant systems, and to acknowledge and center people's lived experiences.

An example of such work may be seen in a recent, supervised session with our collective of therapists who have completed different levels of the IMBPT program. We asked everyone to notice what happened in their bodies as they heard stories about Dalit, Adivasi, and upper caste clients. Our anti-caste commitment makes it important to have therapists who can discern how bodies hold stories of oppression and of privilege differently. Sitting together and recognizing the nuances in moment-to-moment responses helped us unpack the emotions and thoughts around privilege and oppression arising in the therapists' bodies. As a team of AFAB (assigned female at birth) persons – some queer, some cis-het, mainly upper caste and of different religious identities – we soon became aware of our instant responses when it came to understanding people from one's own oppressed locations (gender, sexuality, and so on), and of how we typically overlooked oppressions caused by our privileged identities (particularly caste). We realized how we tend to hold space in an overly sympathetic as well as apologetic way when we inhabit upper caste bodies, resorting to using therapy in its individualistic form (which focuses on challenging and changing the client's thoughts and feelings, rather than taking on board structural factors). It became apparent how the privileged body of the therapist could impact marginalized bodies in therapy spaces.

In our work with various communities, this framework has been a useful starting point in working with those in positions of power. Conversations with stakeholders entail facilitating an understanding of what happens in the body when speaking of the impact of systemic inequalities within their communities. In noticing how anger, hope, care feel in the body, we begin to tap into nuanced ways of training people in power to listen to voices from the margins and to center these.

In grounding this work of advocacy within our bodies, the hope is to discover ways of relating to ourselves and the world that bring us ease, openness, and rootedness in our bodies, allowing us to sustain the work of activism and healing. We have found it to be a deeply enriching, sometimes painful, yet largely yet largely a joyous journey, in which training spaces are held in embodied care.

Pooja Agarwal (she/her) is a therapist and supervisor at Pause for Perspective. She integrates Mindfulness and Narrative practices in her work with individuals, young people, and groups, leads the organization's Fellowship program, and is a co-teacher on the IMBPT program. Her work is rooted in anti-oppressive social justice principles, and an affirmative stance.

Aarathi Selvan (she/they) is the Founder-Director of Pause for Perspective, Hyderabad. She is a supervisor, teacher, and therapist, and leads a team of over 20 MHPs. Her work is informed by principles of social justice, and feminist perspectives. She integrates Narrative- and Mindfulness-informed modalities into her trainings.

SERVICE DELIVERY

Psychosocial Support for the Riot-Affected: Factoring in Financial Security

A critique of the biomedical model of post-riot counselling services as being reductive, in divorcing mental health issues from the deeper social context

BY RADHIKA KANNAN

introduction

This article is a reflection on psychosocial support in the aftermath of the communal riots in Northeast Delhi in 2020, followed by the onset of the COVID-19 pandemic. It makes the case that financial aid is crucial to the post-riot rehabilitation response, for individuals whose mental health is already exacerbated by cycles of poverty. The restoration of livelihoods needs a rights-based approach, in which ideas of rehabilitation are co-designed, and built together, with those affected by the violence. The overall aim here is to shed light on how the psychosocial health of individuals, while undoubtedly made worse by a riot, is further exacerbated by structural stressors – such as minority religious position[1], and poverty – which must inform post-riot rehabilitation services.

The evidence for these assertions was generated through my fundraising efforts over a period of 18 months, to provide sustained support to two migrant families, whom I contacted while attempting to locate women with disabilities (WwD) at the Idgah Camp, Delhi. The marginalized position of WwD in India renders them particularly vulnerable.[2]

context

To understand the impact of the communal riots in early February, 2020 on persons with disabilities, I volunteered with the National Platform for the Rights of the Disabled (NPRD), an organization that advocates for policies to secure rights for the disabled. The first visit to the field enabled us (volunteers) to meet riot-affected families, and conduct needs assessment[3] for WwD in the camp.[4]

Visits to the camp revealed how funds and donations were organized. The camp itself resembled a bazaar where civil society organizations

Other forms of distress directly pertaining to the body, such as chronic pain or illness, eating disorders, health-related anxiety, and health conditions and disabilities that are not externally visible, can affect mental health as well.

and pharma companies provided healthcare, temporary social security, rations, and cash. Access to these services happened through negotiations with the service providers, to convince whom each "riot victim"[5] had to perform their trauma repeatedly. The camp saw new visitors daily – citizens-turned-saviours[6] – who would frequently and casually question those living in the camps about their experiences, ignoring all ethical considerations around how such a conversation might affect the narrator, or be placed in the larger landscape where stories about trauma were ways to secure aid.[7]

Within less than a month, due to the COVID-19 pandemic, the camp was evacuated, without sufficient notice being given. Families were asked to go back to the very homes that were no longer safe spaces. What had felt like a quick fix, meant to last only till everyone got enough assistance, turned into a never-ending story. This piece sheds light on how a psychosocial response to a riot may be orchestrated through financial support, and long term needs-based engagement, even by a layperson.[8]

questioning the ration kit

After a communal riot in which affected persons lose their livelihood and homes, providing dry rations to those affected is a common relief practice. A ration drive is organized, for distributing packages containing fixed amounts of sugar, flour, rice, daal, salt, cooking oil, and so on. Such ration kits are not tailor-made to family size, or dietary practices. Often, the items are not of good quality, being the result of several cost cuts, and reflecting the view that the poor do not need quality food, and that rather than complaining, they should be grateful for whatever they are receiving.[9] These kits cater to rehabilitation only in the short term, which is why they become a symbol erroneously suggesting that the post-traumatic impact will be short-lived, and life will magically return to how things were.

Through the fundraiser I organized, I overturned these defining tenets, so that the ration kit took into account varied circumstances. Firstly, it was based on the family's size, their nutritional needs, and dietary habits. For instance, for those with specific nutrition needs, buffalo milk was included instead of the much cheaper toned or double toned milk, as were fruits. Provision was made for medical tests and medication, according to health contingencies.[10] Changes to the range of items each family needed were made without asking for justifications. This approach was based on a shift in understanding – that doing just the "basic minimum" does not work in the long run, and may please the provider more than it satisfies the receiver. Around the month of Eid, additional monetary support was given to the families so they could celebrate through traditional foods. Both families said that eating gosht helped them temporarily forget recent events.

reimagining and reframing the psychosocial problem

While providing financial aid to these families in the initial months, I received many requests from counsellors who wanted to speak with "riot victims" and help them with post-traumatic stress. From my interactions with the two women and their families, it was apparent they did not wish to speak to anybody about the incidents that had made them homeless. Not only was the notion of talking to a counsellor alien to them, it seemed to add to their present tension.[11] At first, I let biomedical services reach out to them, but soon realized that not only were these services isolating the mental health issues from the underlying social context, they were carried out insensitively.

A few agencies had begun providing tele-counselling services at the start of the pandemic. In one of the two families I was working with, a male counsellor reached out to one of the women, for whom speaking to a stranger, especially male, felt culturally inappropriate. Besides, the families were not helped to understand what purpose might be achieved by recalling traumatic personal experiences. A further issue with tele-counselling was that the counsellor either changed between sessions, or didn't recollect details correctly. Thus free therapy for poor people meant poor services, during which the interactions may have caused more scarring, instead of being helpful.[12]

Looking at these concerns from a psychosocial lens means acknowledging that psychological relief for these families was intrinsically linked to financial security – monetary relief, as in repayment of debts which trapped them in the cycle of poverty, was all that seemed to ease their tension, enabling them to live with some degree of comfort in the middle of the deadly pandemic. Factories had shut down; there was no work. Having enough gas to cook, enough flour, enough rent money, not only helped them survive but also saved them from shame in the eyes of landlords, neighbours, relatives. While locating post-riot mental health crises, financial security is an extremely important factor in sketching different pathways to recovery.

recommendations for blended psychosocial services

- In the short term, psychosocial aid to the marginalized and the poor must layer their services with better customized financial support that sustains families, giving them hope and the will to live
- In the long term, if organizations involved in rehabilitation for marginalized communities offered training, education and employment support, the root causes of poverty and its impact on mental health would be met with empowerment and sustainability
- Training local people and community leaders in psychosocial first aid to identify immediate needs and stressors, as well as enabling a local peer network for the sharing of problems, would prove beneficial

Radhika Kannan holds an MPhil in Sociology, Delhi School of Economics. Her dissertation focused on the lived experiences of hikikomori in contemporary Japan. She is interested in how categories of distress find/lose their way into/from diagnostic manuals. Radhika has organised two fundraisers in recent times. She leads the Mental Health and Psychosocial well-being vertical at Vihara Innovation Network.

MHI's Work

Innovation
Insights
Philanthropy
Challenges
Lived Realities

We work with multiple stakeholders, including non-profit organizations, Governments, mental health professionals and activists in the pursuit of an INCLUSIVE Mental Health ecosystem. Our core strategies include ADVOCACY, CAPACITY BUILDING, GRANTMAKING, KNOWLEDGE CREATION and TRAINING.

MHI's work

MHI has ventured beyond grantmaking to build a body of work that leverages our strengths in knowledge creation and communication. Our initiatives centre gender, sexuality, and knowledge from the margins in mental health practice.

Re-Vision

mental health of entrepreneurs
MHI collaborated with ASCENT Foundation, a peer-to-peer platform for entrepreneurs, to study the mental health experiences of growth-ready Indian entrepreneurs. The results of the study were published in November 2019. Following this, a qualitative analysis of the report titled 'Business as Identity' was published in September 2020. This report was envisioned as a guide for Mental Health Practitioners. The primary finding that emerged from the study was that entrepreneurs in India have a persistent fear of failure. Their other top stressors included financial monitoring and management, and workforce management. In April 2021, to follow up on the study, MHI and Ascent Foundation, conducted a Focus Group Discussion with entrepreneurs to understand the tailored-support entrepreneurs need as well as the impact of COVID on their well-being. In the discussion, the entrepreneurs expressed the need for specific resources such as self-care exercises, readings on mental health, assessment resources, and a list of Mental Health Practitioners.
MHI will support the Ascent Foundation to create content on entrepreneurial well-being.

gender and sexuality-based initiatives
QACP: Queer Affirmative Counselling Practice (QACP) is a 6-day certificate course to reorient Mental Health Practitioners (psychologists, psychiatrists, social workers, counsellors) to an anti-oppressive therapeutic practice. The faculty at the course are all queer Mental Health Practitioners themselves. The training covers both perspective-building to recognise inequalities and their impact on mental health and also provides tools to address distress and promote well-being of LGBTQIA+ persons. These perspectives and tools support practitioners to modify their ongoing practice to make it queer affirmative. Launched in January 2019, 250+ mental health practitioners across 10+ cities in India have been trained in queer affirmative practice until July 2021.

PSP: Peer Support Practices (PSP) is a course for queer-trans collectives and organizations. The objective of the course is to support ongoing work that collectives and organizations do within these communities while also, helping these efforts to scale and to reach more queer-trans persons. PSP uses knowledge from the margins, highlights good practices and ethics, and challenges a top-down hierarchy of psy-expert/clinical paradigms in important ways. The course imparts skills to work with those who seek support, ethical paradigms around boundary setting, perspective-building, and self-care practices.

MHI has organized Peer Support Trainings with Sappho for Equality (Kolkata), Nazariya QFRG (New Delhi), Sahayatrika, and Queerala (Kerala). As of August 2021, approximately 90 participants from across 10 geographical locations have been trained.

GSMHM: Gender, Sexuality and Mental Health from the Margins (GSMHM) is an introductory workshop style session for educational institutions- for staff, students and Mental Health professionals. The GSMHM facilitators take students through a journey of understanding sexuality and gender in society. The workshop is an opportunity for students to reflect on lived realities and concerns from a sexuality, gender, and mental health perspective. GSMHM explores how cis-heteronormativity informs all lives as well as institutional norms and functioning. The session is a starting point for educational institutions to think about how their campuses can move towards being queer-affirmative spaces.

Engage

youth care network
The COVID-19 pandemic has exacerbated stressors for the youth population and has heightened distress around education and employment prospects. It has also affected access to sexual and reproductive health services and escalated incidences of intra-household and familial violence. Against this backdrop, MHI initiated 'Youth Care Network' (YCN), a four month training module with iCALL Psychosocial Helpline and the YP Foundation in 2020. The project is jointly funded by MHI and the WHO. The objectives of YCN are to build capacities among youth leaders and support them to deliver psychosocial first aid to their peers and in their communities. For the initial cohort, 35 youth leaders across India were selected from a large pool of applicants. The leaders work across various themes such as Sexual and Reproductive Health Rights and Education. A variety of themes were explored, including youth mental health and psychosocial distress, COVID-19 & its psychosocial impact, and queer affirmative psychosocial support, etc. Participants were also trained in providing referrals to Mental Health Practitioners in private and public settings and in undertaking resource mapping exercises, with an emphasis on services, information and resources for the youth population.

government partnerships
MHI is partnering with state governments across the country in an attempt to facilitate effective implementation of the Mental Healthcare Act (2017). This support extends to enabling state governments to create policies and systems for implementation of the Act, build capacity among varied stakeholders to provide mental healthcare services and leverage technology to undertake service delivery. MHI is working closely with the State Government of Bihar and the National Institute of Health and Family Welfare in capacity building and implementation of the Mental Healthcare Act.
In Bihar, MHI is also partnering with the Health and Education department to include mental health within their existing work.

leadership
MHI's CEO, Priti Sridhar, was invited to be a member of the Funding and Policy Council of an initiative called Mental Health and Psychosocial Support in Humanitarian Crises: Setting Consensus-Based Research Priorities for 2021-2030. The initiative is aimed at developing a research agenda for mental health and psychosocial support in humanitarian settings for the next decade (2021-2030) and is funded by the UK's Department for International Development, the Wellcome Trust and the UK's National Institute for Health Research.

MHI's Director, Raj Mariwala, was invited into the Advisory Board of the Lancet Commission on stigma and discrimination. As part of the Board, Raj will provide strategic support on the Commission report and recommend related work that can be included in the Commission, especially in languages other than English.

Raj was also elected to be on the advisory board for Global Mental Health Action Network (GMHAN), a community of mental health professionals from across the world to improve support of mental health globally. As a member of the GMHAN, Priti co-authored a guide, aimed at providing tools to influence finance ministries across the world to proactively make investments in mental health.

MHI also published a toolkit for mental health and well-being at the non-profit workplace. We explored the unique stressors for employees working in the non-profit sector by foregrounding a psychosocial and intersectional approach to employee well-being.

COVID-19 Crisis Reponse 2021

COVID relief
The COVID-19 pandemic and its accompanying lockdowns have huge implications for livelihoods, public health, and mental health, so MHI's COVID relief efforts had to go beyond mental health support and address relief support as well. Partnering with over 25 community-based organizations across 22 states, MHI funded food rations, medicine, rents and also by providing cash transfers, as psychosocial distress is related to structural exclusion. Special efforts were made to reach out to smaller NGOs and informal collectives working on the ground who are often denied access to relief funding.

we provided relief support to 28 NGO's, CBO's and Collectives

- Adivasi Mahila Aapsi Madad Pahal
- Agadhbodh Foundation
- Ambedkarite Women's Era
- Anubhuti Trust
- Burans
- Devadasi Vimochana Vedike
- Education Society Chamba
- Gram Parivartan Prabodhini
- Jan Jagran Shakti Sangathan
- Jeeva
- Karnataka Vikalachetanara Samasthe
- KOSISH Charitable Trust
- Lok Kalyan Pratishtan
- Moitrisanjog
- Nirdhar Samajik Sevabhavi Sanstha
- Purva Bharati Educational Trust
- People's Voice Korav
- Raahi
- SAATHII
- Sahara Sakshrta Educational & Social Welfare Society
- Samajik Shodh Evam Vikas Kendra (SSEVK)
- Sangvari Gond Youth Network
- Vasantham Maatru Thiranaligal Group
- Volunteers in Jodhpur
- Voice for Peace
- Wavye Foundation
- Ya_All: Youth Network
- Yusuf Meherally Centre

vulnerable marginalised communities

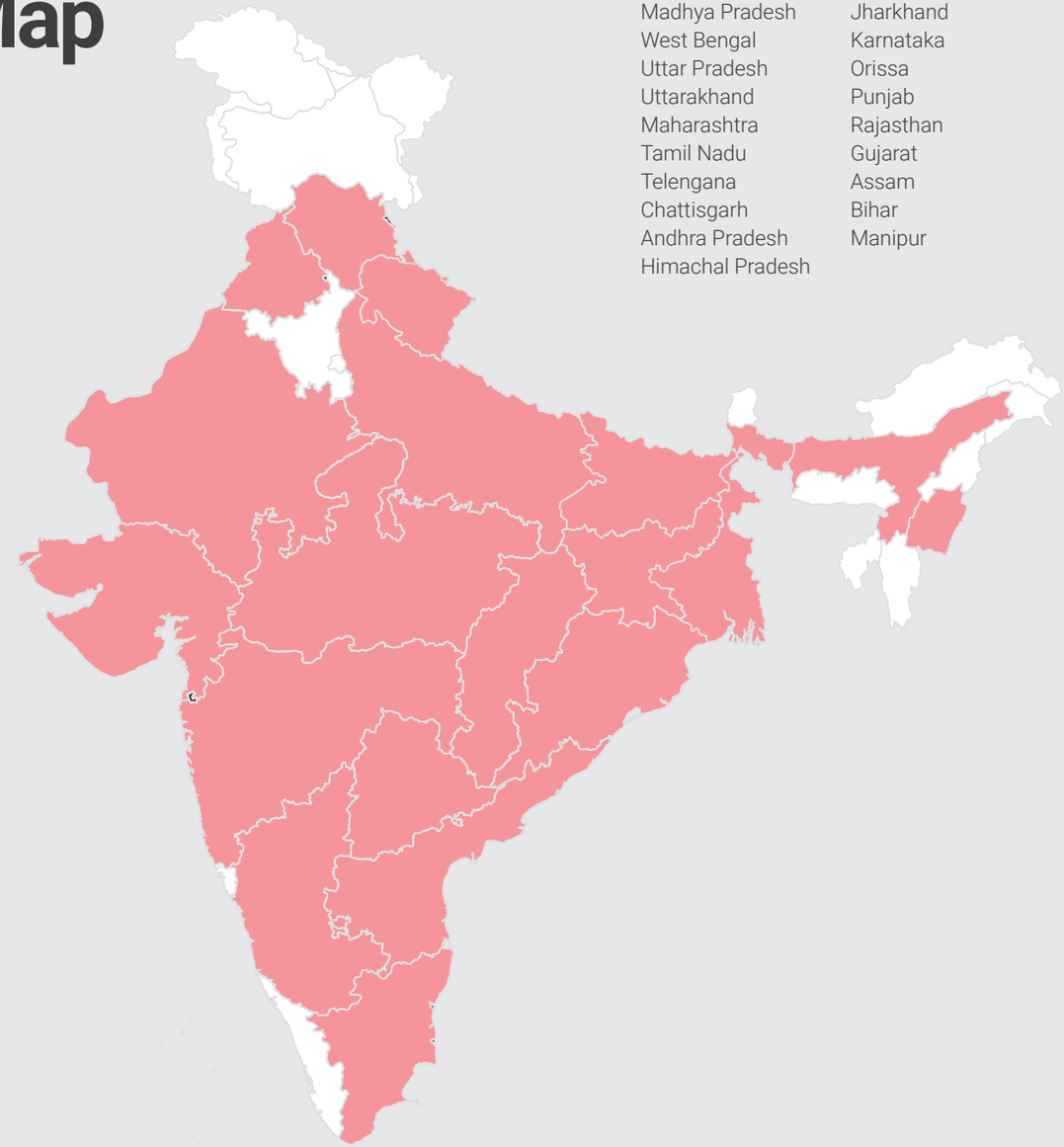
- adults with intellectual disabilities
- persons living with disabilities
- Nomadic Tribe /Scheduled Caste / Scheduled Tribe
- Muslim communities
- migrant workers
- daily wage earners
- persons living with HIV/AIDS
- antenatal women
- postnatal women
- elderly persons
- persons who identify as trans-queer
- sex workers
- trans persons who are sex workers
- persons living in urban bastis
- persons who are homeless

COVID Impact Map

COVID RELIEF

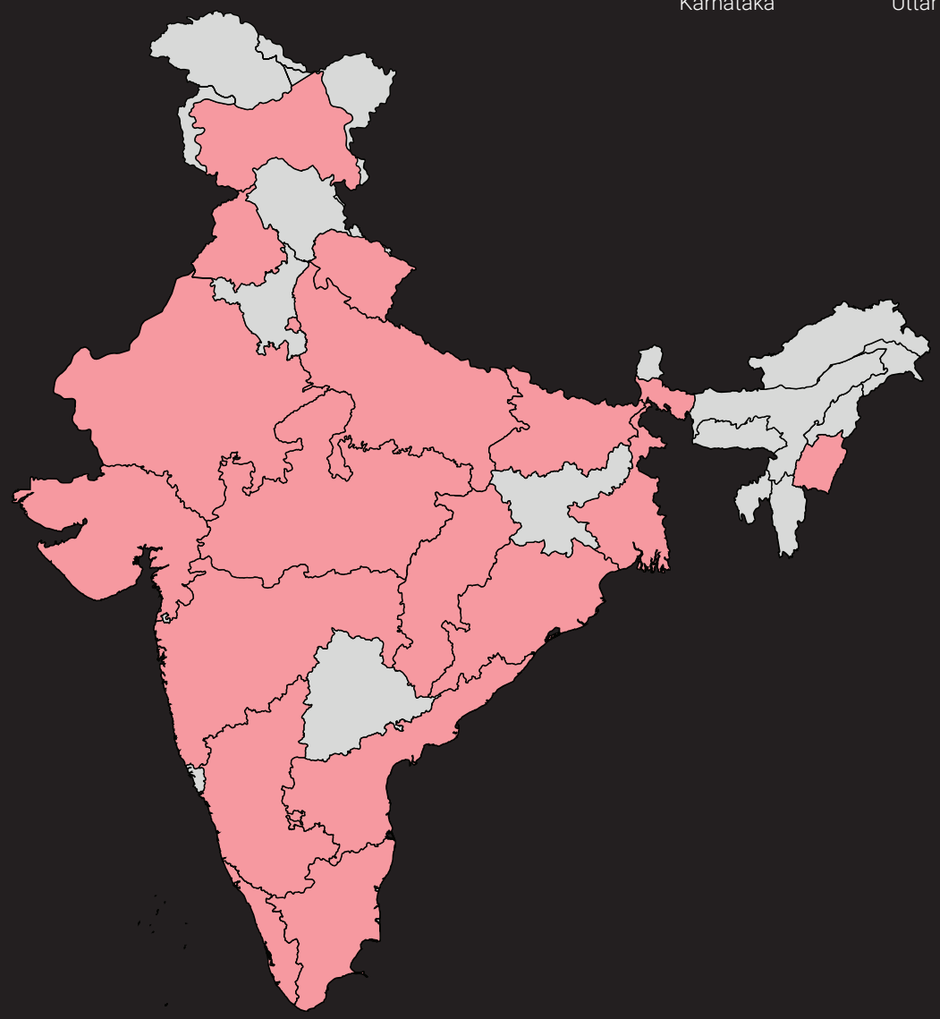
not included in service delivery 22834
CBOs, NGOs and collectives 28
states 19

Madhya Pradesh
West Bengal
Uttar Pradesh
Uttarakhand
Maharashtra
Tamil Nadu
Telengana
Chattisgarh
Andhra Pradesh
Himachal Pradesh
Jharkhand
Karnataka
Orissa
Punjab
Rajasthan
Gujarat
Assam
Bihar
Manipur



Primary Impact Map

Maharashtra
West Bengal
Odisha
Delhi
Uttrakhand
Gujarat
Chattisgarh
Kashmir
Karnataka
Kerela
Manipur
Madhya Pradesh
Andhra Pradesh
Tamil Nadu
Rajasthan
Punjab
Bihar
Uttar Pradesh



Demographic Snapshot

MHI goals include reaching out to and making mental health accessible to marginalized populations and communities. To bridge the mental health care gap for persons facing structural oppression — it is even more important to provide psychosocial interventions and supports.

TOTAL REACH OF OUR PARTNERS

1,37,422
women

5,873
lgbtq+

GENDER

9,349

DISABILITY

3,545

RELIGIOUS MINORITY

21,103
youth

AGE

16,231
sc/st/obc / indigenous & tribal

CASTE

19,813

MIGRANTS

100

ANY OTHER

The 5 Pillars

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

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

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.

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

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

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.

3,29,349 PERSONS

74,465 PERSONS

7 PRESENTATIONS + PUBLICATIONS

3,710 PERSONS

16,036 PERSONS

4,23,560
sum of persons impacted

Partners

As of June 30th, MHI works with 20 partners on 22 projects, in 11 languages with communities, institutions, and governments for service delivery, advocacy, deinstitutionalisation, capacity building, community mental health, law and policy, LGBTQIA+, and youth mental health.

partners are

- Activists
- Service Providers
- Researchers

that affect state & civil society at these levels

- Government
- Institutions
- Communities

partners prior to 2020

ANJALI • ANUBHUTI TRUST • BAPU TRUST • BASIC NEEDS INDIA (BNI) • BURANS • CENTRE FOR MENTAL HEALTH LAW AND POLICY (CMHLP) • DARJEELING LADENLA ROAD PRERNA (DLR PRERNA) • iCALL• ISWAR SANKALPA• KASHMIR LIFELINE (KLL) • MANN • RAAHI • RESOURCE CELL FOR JUVENILE JUSTICE (RCJJ) • SCHIZOPHRENIA AWARENESS ASSOCIATION (SAA)• SHIVAR FOUNDATION • SOCIETY FOR NUTRITION EDUCATION, HEALTH ACTION (SNEHA) • SUKOON • WAYVE FOUNDATION • YA-ALL

partners since April 2020	Bebaak Collective	DISHA	Moitirisanjog Society	Nirangal	WAYVE Foundation
PROJECT / INITIATIVE	**mental health of muslims in India**	**crime victim rehabilation**	**psychosocial and peer support to LGBTQ communities**	**psychosocial and peer support to LGBTQ communities**	**building and supporting marginalized women's leadership**
NATURE OF PARTNER					
STATE & CIVIL SOCIETY					
LOCATION	Maharashtra	Maharashtra	West Bengal	Tamil Nadu	Bihar, UP, Gujarat, Chattisgarh
DETAIL	Bebaak Collective (meaning 'Voices of the Fearless') is a Maharashtra-wide collective that primarily works in Mumbai. The collective offers a safe space for reading, learning, sharing as well as an avenue for campaigning, for women from marginalized communities, especially Muslim women. The collective offers a space for conversations on mental health, including those issues caused by the external environment. Women can use the opportunity to speak about the discrimination and harassment they experience in their daily lives. Bebaak Collective has set up a community centre in Nagpada near Mumbai and has started a helpline for Muslim women. The centre provides crisis intervention and mental health support.	Disha, through its Crime Victim Rehabilitation Project, works with the survivors and victims of serious and gendered crimes, providing free and direct, multifaceted support services including psychosocial, medical, legal, and financial support and facilitating access and use of Governmental schemes and entitlements. It also parallelly works to sensitize government and police officials, who are often first responders to survivors of violent crimes and their family members, to better understand the needs of victims, their rights, and the responsibility of state actors in helping to realize such rights. Disha has been instrumental in the advocacy and formation of Maharashtra's implementation of the Victim Compensation Scheme.	With its beginnings as an informal support group for transpersons, Moitrisanjog evolved into a community-based organization that works with persons from marginalized genders and sexualities. In the Psychosocial and Peer Support to LGBTQ communities project, Moitrisanjog hosts safe spaces for community gatherings, drop-in centres to access peer support, livelihood activities, and psychosocial and health services. It also organizes full-day community meetings at the block-level where, apart from discussing local issues specific to the block, community members engage with current affairs such as the Trans Act, local, and state-level elections. Moitrisanjog also conducts sensitization workshops for college students and youth on LGBTQ+ issues.	With a focus on supporting persons marginalized by gender identity, Nirangal takes an intersectional approach to human rights and social justice, working closely with solidarity groups to fight against injustice based on caste, community, language, religion etc. Through its program, 'Psychosocial and Peer Support to LGBTQ Communities' Nirangal strengthens LGBTQI+ peer support groups and advocacy training to collectives and informal groups. It also trains students, legal, medical, media, and mental health professionals on gender and sexuality, particularly on issues affecting the LGBTQI+ community, and how these professionals can incorporate affirmative practices in their work. Nirangal works across Tamil Nadu.	In the 'Building and Supporting Marginalized Women's Leadership' project, WAYVE Foundation builds capacity among young women from marginalized caste and religious backgrounds to become leaders and addresses the psychosocial needs rooted in the structural discrimination and violence they have faced. These leaders in turn go on to start or continue their community-based work with skills and knowledge from the training. In a year-long training programme with 35 grassroots women leaders, WAYVE Foundation trains women on fundamental and constitutional rights relating to social protection, education, economic and political participation, mental health, and psychosocial first aid. Each leader is then offered a personalised mentorship program.

Glossary

ACCULTURATION refers to the cultural changes that arise from the contact of two or more cultures.

ACQUIRED DISABILITY refers to a condition that originates in an individual after birth due to environmental or extrinsic factors.

BIOMEDICAL APPROACH is based on a disease- prevention model that prioritizes the use of medication for treatment while ignoring experiences of abuse, poverty, racial, caste and gender inequalities.

CASTEISM refers to the discrimination of an individual or group of persons based on the caste they identify it, favouring dominant and upper castes and groups.

CIS-HETERONORMATIVE BIAS Individual, institutional and cultural belief that heterosexuality is the only normal and acceptable sexual orientation and that identifying as cis is the only valid gender identity. Such a bias leads to discrimination against other sexualities and gender identities.

CLINICAL BIAS refers to the bias that occurs because of the beliefs and actions of an individual practitioner. This occurs predominantly due to preconceived notions about a client's sexuality, ethnicity, religion or gender.

COLOURISM refers to the discrimination of an individual or a group of persons based on skin tone. Colourism often favours groups or ethnicities with light-skinned members.

CONGENITAL DISABILITY refers to a genetic or environmental condition that is present in an individual from birth.

GENDER-BASED VIOLENCE is defined as violence directed against a person or group of persons because of their gender identity. It can also refer to violence that disproportionately affects a particular gender.

IDENTITY-BASED DISCRIMINATION refers to the discrimination of an individual or groups of people based on the ethnicity, culture, religion, gender, sexuality, nationality, race or caste they identify with.

INTERSECTIONAL FEMINISM centres the different ways in which caste, class, religion, disability and sexuality contribute to how women experience discrimination or sexism.

ISLAMOPHOBIA is the systemic prejudice against Islam as a religion and the systemic marginalization of persons identifying as Muslim.

PATHOLOGIZATION This refers to a) branding persons with mental health issues as 'ill' b) over-reliance on medication and 'expert' diagnosis of one's mental health. This often puts persons with mental health issues at risk of abusive, unethical and involuntary treatments and forced institutionalization.

POST TRAUMATIC STRESS DISORDER (PTSD) is a mental health condition that occurs from having experienced a traumatic or stressful event.

QUEER-AFFIRMATIVE is an approach that embraces a positive and validating view of queer identities.

RIGHTS-BASED APPROACH to mental health ensures that every person has the capacity to make decisions regarding their mental health care and treatment plans and give or withhold consent to any medical procedures. It will also require advocating for laws that can help secure the rights of persons with mental illness and recognizing that their rights will be legally enforceable.

SOCIAL EXCLUSION Refers to the exclusion from the prevailing social system. Typically those excluded do not have the same rights and privileges as those occupying the centre of the system. This can be due to discrimination along class, caste, religious, sexuality, citizenship and gendered lines.

STRUCTURAL OPPRESSION This refers to oppression deeply embedded in social, political and economic institutions, arising out of dominant ideas around gender, race, caste, religion and sexuality, thereby denying those in the margins access to and opportunities for growth and justice.

SUICIDAL IDEATION (also known as suicidal thoughts or ideas) is a broad term to describe contemplation, wishes and preoccupations with death by suicide.

TRAUMA-INFORMED is an approach that validates and understands the pervasive nature of trauma in an individual's life.

USER-SURVIVOR refers to persons with lived experience of (currently or formerly) and those who may have survived mental health issues, psychosocial disabilities, psychiatric and mental health services and institutions.

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Psychosocial support for the riot affected: Factoring in Financial Security

1) Here I will only be considering poverty, and not minority religion status, which would require a separate article.
2) One out of the two women who benefited from this fundraiser had to be carried by three of her brothers, in the form of a human palanquin.
3) Volunteers are trained to use a Needs Assessment Form, which was developed by NPRD and its collaborator to understand the needs of people who were either already disabled, or had become disabled through injuries in the riots. The form provides a sense of the family's socioeconomic status, the damages incurred to property, as well as access to a disability certificate as well as to rations.
4) We got in touch with Danish, a local social worker who had been involved in the provision of food and other basic amenities immediately after the riots; he put us in touch with families of people with disabilities.
5) The commonly used term to refer to anyone who suffered during the riots.
6) I write "saviours" because many persons present at the Idgah camp came there to take photos of what they saw, to put up on their social media profiles. Some part of this "being there" showcases a form of "saviour complex" that has become a part of the fabric of showing oneself to be "woke" and caring.
7) While I do not see any problem with the bartering of a story of trauma for a service, there was something about the excess of such interactions that not only made me queasy but also made me reflect on what it takes to get basic services.
8) I have not once in those 18 months asked families to narrate "what happened that day" – because all the other signifiers around why they were seeking my support made the happenings evident. I was also on my guard against turning into a makeshift counsellor, which has become a trend of sorts on social media where people request anybody to open up to them if they are going through a tough time psychologically – something that I find dangerous.
9) I do understand that many times those who arrange rations are trying their best to fix something instead of nothing, but I am saying that this is not enough. Asking for more tags the recipients as selfish, eroding the qualifiers of their poverty, helplessness and "riot victim" status. A poor person thus becomes synonymous with someone who must be content with whatever she receives. Being quiet and grateful is a part of the package.
10) Ethnographic accounts on low income households' expenditure on food suggest rocketing expenses going into Out of Pocket Expenditure(OoPE), increasing the cost of living in hazardous socio-economic conditions. The riot also led to many somatic conditions such as fever, sleeplessness and weakness, for which individuals required medication.
11) Tension here is different from the English word "tension" as it finds its way into Hindi. It connotes any kind of stress, short- or long-term. "Tension ho raha hai" ('I/they have tension' or 'Tension is happening') is colloquially very common.
12) This may be read alongside the statistics wherein only 1 psychiatrist is available for a population of 100,000 people in LMICs like India. Such instances only resonate as the lived experience of such a statistic.

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, right-based, are 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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