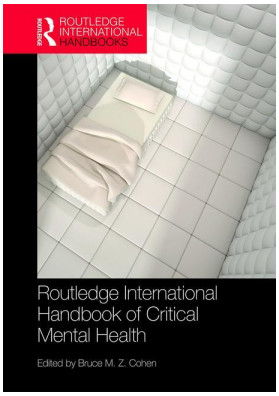


**Routledge International Handbook of Critical Mental Health**

Bruce M. Z. Cohen

# Problematising Global Mental Health

Publication details
https://www.routledgehandbooks.com/doi/10.4324/9781315399584.ch25
Clement Bayetti, Sumeet Jain
**Published online on: 28 Sep 2017**

# 25

# Problematising Global Mental Health

*Clement Bayetti and Sumeet Jain*

The emergence of the field of Global Mental Health (GMH) in the last ten years has had a significant influence on the orientation and development of discourses around mental health in the Global South. GMH can be conceptualised as a set of initiatives that promote the evidence-based 'scale up' of mental health services in the Global South, to improve human rights of people with mental health difficulties and their access to care (Jain and Orr 2016). The field emerged in the context of growing epidemiological research on the global burden of disorders, including their economic burden in treatment costs and loss of economic output, and in the context of a series of international reports on mental health provision (Desjarlais *et al.* 1995; Lancet Global Mental Health Group 2007; World Health Organization 2001). A key moment was the launch of the 2007 Lancet Global Mental Health series (Patel 2012), which set out an agenda for action to address the 'burden' of mental disorders. Linked to this was the emergence of the Movement for Global Mental Health (MGMH), driven by key architects of the Lancet series and supported by key international mental health institutions such as the Institute of Psychiatry, the London School of Hygiene and Tropical Medicine and the World Health Organization (WHO). MGMH rests on two pillars: improving access to care by closing a perceived 'treatment gap' between the availability of services and the number of people needing such services, and addressing the human rights of people with mental disorders (Patel 2012). MGMH encompasses a coalition of mental health professionals, policy-makers and service users and carers, and now comprises 200 institutions and 10,000 individuals.

In the past ten years, GMH has emerged as an academic discipline including postgraduate courses, a growing body of research studies, associated academic publications and international conferences. A key aspect of GMH has been the emphasis on evidence, supported by a series of studies to build the case for mental health interventions and thereby facilitate policy efforts.

With the development of GMH as a discipline and of MGMH, a growing number of critics also emerged, questioning some of the fundamental assumptions underpinning both the discipline and the movement. The critiques centre on the following three broad themes:

1. Universality of mental disorders: critics argue that psychiatric categories deployed globally may not reflect lived realities (Das and Rao 2012; Mills and White 2017) and that these categories are Western impositions and not universally applicable (Fernando 2014; Mills

2014; Summerfield 2008). The discourse of psychiatric disorders as an 'epidemic' drawing on global burden data has shaped particular approaches to interventions in GMH, generating demands for 'urgent' public policy responses. This 'urgency' is used to justify the resort to universal categories;

2. What types of evidence are shaping GMH/MGMH interventions: an important critique of GMH relates to the structural mechanisms (funding, publishing) that privilege particular forms of 'evidence' (such as randomised control trials) and minimise the value of other forms of evidence and knowledge (for example, qualitative and ethnographic data) (Jain and Orr 2016; Mills and White 2017). This relates more broadly to the question of what is seen as valid 'evidence' (Ecks 2008);
3. An over-reliance on technical interventions within GMH discourses: the focus on particular forms of 'evidence' generates a reliance on particular forms of 'intervention' in GMH discourses – technical approaches such as psychopharmaceuticals and easily measurable forms of psycho-social intervention. This lack of attention to a multiplicity of approaches limits the space for alternatives, facilitating a 'monoculture' of approaches to addressing mental health (Davar 2014) and giving limited consideration to the social and cultural determinants of mental health (Das and Rao 2012).

It is important to note the growing multifaceted and multi- and interdisciplinary nature of GMH. A field largely dominated by psychiatry and epidemiology, a focus on disease has faced resistance as described above, leading to vitriolic debates (Bemme and D'souza 2012). In recent years, scholars – including social scientists, mental health practitioners and experts by experience – have offered other perspectives that have sought to move beyond these divides by: examining the 'functioning' of GMH (Bemme and D'souza 2014); exploring the contributions of ethnographic methods and medical anthropology to understand GMH and its projects (Jain and Orr 2016); considering the contribution of more marginal mental health disciplines to GMH (Orr and Jain 2014); problematising the role of user/survivors in GMH (Swerdfager 2016b); and opening up new aspects of the role of human rights in GMH – for example, the role of the UN Convention on the Rights of Persons with Disabilities (Davar 2012; Read *et al.* 2009; Stavert 2017; Transforming Communities for Inclusion: A Trans-Asia Initiative 2013). This interdisciplinary work has potential to advance understandings of global mental health, shifting the very basis of GMH towards a discipline that encompasses a range of voices and disciplines and constitutes a '(re)claiming' of the 'GMH' label.

In view of these arguments, GMH has recently been dominated by a 'hostile intellectual climate' characterised by deadlocked intellectual exchanges. We suggest that this impasse might be overcome by reorientating the underlying principles of GMH from a developmental and epidemiological approach which frames mental illness as a burden/treatment dichotomy, to an ecological framework in which experiences of mental ill-health are understood in terms of suffering and care. This, in turn, might provide GMH with an important opportunity to rethink the sustainability of its approach.

## Global Mental Health from the bottom-up: engaging with people and communities in the design of services and interventions

The development of MGMH and the evolution of GMH as a discipline position it as a largely top-down venture. The critiques summarised above would support this. Over-dominance of biomedical psychiatric knowledge, emphasis on technical interventions and the exclusion of diverse sources of evidence all illustrate how particular forms of knowledge and expertise shape MGMH

and GMH as a discipline. We do not dispute the importance of the aims of MGMH and the framing of GMH as a discipline. Improving access to care and support for mental health difficulties and ensuring the human rights of those with psycho-social disabilities are important objectives. However, the relative absence of the voices of the individuals and communities who are the 'objects' of interventions limits dialogue between different forms of knowledge in the design of services. Such a dialogue and a bottom-up approach are crucial if responses to mental health difficulties are to be appropriate and relevant to local concerns (Jadhav *et al.* 2015; Kirmayer and Pederson 2014). Moreover, a wider reorientation of GMH depends on the presence of a diversity of voices and disciplines (Jain and Orr 2016).

Central to developing this bottom-up approach and dialogue is the advancement of community engagement agendas towards genuine co-production in which experts by experience play central roles in commissioning, designing, implementing and evaluating responses to psychological distress. Issues of citizen engagement and community participation have been much discussed in health and development discourses and there is an established link between community participation and improved health outcomes (Rifkin 2014). Moving towards a co-production approach as core to GMH requires a consideration of power inequalities that shape relationships between professionals and communities (Campbell and Burgess 2012), including the limited voices of experts by experience in such discourses (Swerdfager 2016b; see linked commentaries from Cohen 2016, Jain 2016 and Swerdfager 2016a). Bridging these inequalities requires recognition of the diverse knowledge and experience that communities bring in relation to their own lives and the potential of these to reshape mental health care.

The community competence framework applied to GMH by Campbell and Burgess (2012: 389) provides an approach to engage with these power differentials (for an application of this framework, see Burgess and Mathias 2017). Community competence is defined by Campbell and Burgess (2012: 389) as 'the ability of community members to participate effectively in efforts to promote prevention, care, treatment and advocacy' through three dimensions. The first relates to community member's knowledge – their ability to recognise psychological distress and seek appropriate support. This dimension is crucial, as a key challenge in GMH relates to the relationship between dominant biomedical psychiatric conceptions and a range of local understandings of psychological distress (Campbell and Burgess 2012). The disciplines of cultural psychiatry and medical anthropology offer the potential to inform dialogue around understandings of distress (Jain 2016; Kirmayer and Pedersen 2014). However, critics question the impact of cultural psychiatry on practice in low-income nations (Jadhav 2004) and the discipline's commitment to user/survivor perspectives (Swerdfager 2016a, 2016b). Enabling the dialogues that would ensure the embedding of user/survivor perspectives in service design and delivery would be supported by the second dimension of the community competence framework: access to 'safe social spaces' that would allow integration of different forms of knowledge (for example, local and medical knowledge). These spaces would provide opportunities for critical engagement around the social and cultural factors that shape distress, in turn challenging responses and examining how the impact of distress might be addressed, leading to a more 'politicised response' by community members and wider alliances. The third dimension is partnerships and relates to local awareness and the ability to access external support and resources. An important aspect of this approach is the idea of 'receptive social environments' – that, along with building community capacities and voice, it is crucial to build environments in which powerful actors can listen and engage with the less powerful. Both the second and third dimensions highlight for us the important shift needed within GMH in how people are perceived towards a view of individuals, families and communities as having capacities and assets which can shape their own well-being. An emphasis on the narrative of patients and community is an important step to reframe the underlying principles of

GMH and its services/interventions around the suffering and care needs of people/community in vernacular terms, leading to culturally valid solutions (Jadhav 2009).

## Towards an ecological approach to global mental health

While the use of participatory approaches focusing on patients' narratives and expertise within service design and delivery may yield important positive outcomes (such as better therapeutic engagement, increased adherence and/or enhanced clinical management), it may also be an essential step in rethinking the conceptual underpinnings of GMH. Notably, such an approach may challenge the discipline's indiscriminate use of reductive psychiatric diagnostic categories in framing and justifying its objective of addressing the burden of mental 'disorders'. Indeed, an emphasis on the validity and complexity of patients' suffering would require a shift from a medical approach in which 'disorders' are treated, to a more humanistic form of care. This novel focus may allow for a broader understanding of the topology of human suffering. Contrary to conventional psychiatric formulations that emphasise 'social stressors [which have] an impact on the psyche' (Jadhav *et al.* 2015: 12; Kleinman *et al.* 1997), one's narratives and experiences of suffering may thus be situated within a wider framework encompassing socioeconomic and ecological dimensions (Jadhav *et al.* 2015). This 'ecology of forces and factors' (Jadhav *et al.* 2015: 13), acting with variable directionality 'on and by the people suffering and those around him and her' (Jadhav *et al.* 2015: 12), recognises the ways in which 'asymmetric interactions between people, the environment (wildlife, climate, agriculture), and institutions governing both, generate socially toxic landscapes that are actively counter-therapeutic' (Jadhav *et al.* 2015: 13; Jadhav and Barua 2012).

If suffering is to be culturally understood as something shaped by the wider ecologies in which it occurs, so can notions of well-being and recovery from mental ill-health. Increasingly popularised in the Global South (Patel *et al.* 2011), the latter have been deployed by the MGMH as universal constructs, while becoming progressively 'packaged' into tools (Grover *et al.* 2016) to allow for their integration within the service-driven agenda of the discipline. This is despite various scholarly calls to critically appraise the cultural validity of such concepts (Bayetti *et al.* 2016; O'Hagan, 2004) and multiple service-user critiques of their recent 'instrumentalisation' (Recovery in the Bin 2016; Rose 2014). Building on participatory approaches, the operationalisation of the notions of well-being and recovery using an ecological framework may address such critiques. People and/or community narratives may provide insights as to the range of interlinked forces and factors shaping individual and collective well-being and recovery, while simultaneously producing a map of crucial local resources used by these actors to foster well-being and support recovery. Taken together, this would allow for the much-needed development of locally rooted and culturally valid models of these concepts, while furthering our understanding of their spatiotemporal nature (Bayetti *et al.* 2016). These models are an important prerequisite in providing alternatives to Western medical and psycho-social methods of addressing suffering and in elevating GMH principles to achieve better care.

More than theoretical constructs, we suggest that it may be possible to modelise these ecological frameworks by using participatory methods such as community-based system dynamics (CBSD). Through a series of group consultations, CBSD aims to render explicit the subjective perceptions that participating individuals have in regard to a complex problem (Hovmand 2013). This allows for the modelisation of this problem through an 'explicit engagement with [its] causal mechanisms' (Trani *et al.* 2016: 3). Such a process may, in turn, reveal the 'interconnections and dependencies that may not be apparent from an external view' (Trani *et al.* 2016: 9), including the feedback relationship existing between the various elements contributing to

the investigated problem. Additionally, this modelisation exercise enhances one's grasp of the 'the dynamic change in system behaviour over time, as well as nonlinear relationships' (Trani *et al.* 2016: 3). Such a method might thus present a good opportunity to use individual and community narratives to understand the wide range of factors and complex relationships shaping those ecological models. This may allow stakeholders to better 'identify issues and prioritize interventions' (Trani *et al.* 2016: 3), thus resulting in policies and programmes better tailored to address the complexity of the local issues they aim to tackle. More than a useful method for policymakers and academics to model complex issues, it also enhances communities' ability to identify issues and 'engage with practical problem solving' (Trani *et al.* 2016: 3). Notions of ownership, capacity and, ultimately, sustainability are therefore intrinsic to this method.

## Implications for the future of global mental health

The notions of ownership, capacity and sustainability remain glaringly absent from GMH and its discourse. As it stands, GMH inherently configures individual and community suffering as the sum of various 'problems' solvable through the intervention of interloping agencies. This places individuals as passive recipients of services, rather than as resourceful actors capable of using assets and existing resources to own and decide how to achieve their desired mental health outcomes. Moreover, the rhetoric of 'urgency' underlying GMH's 'epidemic' approach to human suffering has so far limited the discipline's ability to reflect on its sustainability and that of its endeavours.

We suggest that incorporating the approaches and models previously detailed would allow for a radical, yet positive change of this current configuration. Starting at an individual level, participatory approaches inherently reposition people as having assets and capabilities that can be deployed to develop the coping skills and strategies required to obtain the health outcomes they seek. Rather than being the recipient of an intervention and/or service, patients and users are empowered as integral and active actors in their care. This validation of people's expertise and narratives regarding their suffering and/or well-being may increase their engagement with services while challenging the pervasive stigma of being labelled with a mental illness. The increased social inclusion and renewed sense of citizenship which would result from this change would, additionally, allow a greater access to and use of local resources and infrastructures. At the community level, this would lead to a lower level of dependence on novel services and interventions as individuals become better able to identify and rely on their existing resources and infrastructure to maintain and/or improve their well-being. Our suggested approach thus moves away from the tokenistic 'service-user engagement' currently advocated by GMH (Patel *et al.* 2013) to systematically building competency and resilience in individuals and communities.

Additionally, these changes would have important ramifications at the level of mental health policies and services. Indeed, to make the above vision a reality, the planning, commissioning and design of services must go beyond the current 'problem-service paradigm' (The Holy Cross Centre Trust 2013) in which layers of interventions and services are financed to address a specific 'problem' and obtain a predetermined outcome. Contrary to this paradigm, the person-centred, asset-based approach advocated here intrinsically trusts people and communities to determine what outcomes mean for them when addressing their mental health. What a good outcome might mean for them and 'how it relates to the wholeness of their life rather than just their problem' (The Holy Cross Centre Trust 2013: 15) might vastly differ from the outcomes that services think they should deliver in response to the problem they have been commissioned to address. It is essential for GMH to recognise and address this discrepancy by supporting innovative services positioned as 'learning organisations' (Bayetti 2013), capable of 'co-producing'

multiple outcomes defined by, and relevant to, users and patients within the context of the local ecologies in which they operate.

Rather than depending on traditionally rigid and codified mental health interventions, such services will necessarily adopt flexible, holistic and tailored approaches to best meet the demands and needs of their users, even if such an approach involves 1) supporting people to access and use other resources than the service itself or 2) achieving outcomes normally outside of the remit of mental health services. This is particularly relevant in resource-scarce contexts, where services' willingness to work towards outcomes traditionally outside their remit will intrinsically foster inter-sectoral collaborations and lead to 'better value for money' investments. Furthermore, supporting people to access and use existing resources may reduce the unnecessary duplication of similar solutions capable of delivering comparable outcomes, thereby freeing resources (human and financial) to be redirected to other needs. We believe that this approach will encourage services to engage with the community they serve at a richer and deeper level. This, in turn, would provide services with a more intricate understanding of and ability to successfully help communities. For example, services may become increasingly able to understand and predict the impact of evolving local ecologies, in turn providing communities with insights on how to respond to future challenges.

The latter raises important questions as to the sustainability of GMH, both as a discipline and a set of policies and services. To perdure and stay relevant, GMH must show an ability to evolve and provide answers to the challenges posed by other 'global' phenomena, such as neoliberal capitalism and global warming. The impact of these events on the future stability of our economies, social fabric and socio-political and ecological systems is now undeniable (Klein 2015) and raises profound questions as to the effect that these changes will have on the well-being of people and communities. The predicted increase in human displacement and migration, air pollution, incidence of water- and vector-borne disease and resource scarcity and competition accompanying increasing global temperatures (Environmental Protection Agency 2016) stand as troubling examples of changes that will unquestionably increase the suffering of global communities and worsen their mental health. Moreover, the impact of these changes is likely to be felt unevenly by communities across the world, with the most vulnerable populations, inhabiting the Global South, bearing the brunt of their effect (Mendelsohn *et al.* 2006). More than an opportunity, GMH therefore has a *responsibility* to engage with these global events and account for their impact within the development of policies, services and interventions. Unfortunately, the current nature of GMH has not only disconnected it from local realities but appears to distance it from its actual 'global' calling.

## Conclusion

This chapter has proposed ideas to shift the current GMH paradigm by incorporating some of its existing critiques. Based on a bottom-up approach engaging community and patients through real co-production, this new paradigm recognises these actors as assets with capabilities – experts in their own care and suffering. This new power dynamic resituates the importance and power of personal narratives of suffering by acknowledging the wider ecological framework from which they originate. As such, this proposed approach challenges GMH current service design and delivery in multiple ways. Novel approaches recognising the importance that local ecologies play in community suffering and well-being may, indeed, not need to be 'scaled up', since these peculiarities might disappear (for a critical discussion of scaling in global health, see Adams *et al.* 2016). Furthermore, such an approach may encourage GMH to think of services and interventions able to deliver multiple outcomes, so as to address the wide array of social and ecological

factors at the root of individual and community suffering. In turn, this would challenge GMH's 'silo' thinking by forcing the discipline to account for the growing role of other global trends in shaping the nature of these 'ecologies of suffering'.

## Bibliography


Adams, V., Craig, S. R. and Samen, A. (2016) 'Alternative Accounting in Maternal and Infant Global Health', *Global Public Health*, 11(3): 276–94.

Bayetti, C. (2013) 'Rethinking Public Services as Learning Organization: The Internal and External Challenges Facing Social Enterprises', Social Enterprise, Social Innovation and Care conference, Durham.

Bayetti, C., Jadhav, S. and Jain, S. (2016) 'The Re-Covering Self: A Critique of the Recovery-Based Approach in India's Mental Health Care', *Disability and the Global South*, 3(1): 889–909.

Bemme, D. and D'souza, N. A. (2012) 'Global Mental Health and its Discontents', *Somatosphere*, http://somatosphere.net/2012/07/global-mental-health-and-its-discontents.html (retrieved on 9 March 2017).

Bemme, D. and D'souza, N. A. (2014) 'Global Mental Health and Its Discontents: An Inquiry into the Making of Global and Local Scale', *Transcultural Psychiatry*, 51(6): 850–74.

Burgess, R. and Mathias, K. (2017) 'Community Mental Health Competencies: A New Vision for Global Mental Health', in White, R. G., Jain, S., Orr, D. and Read, U. (eds), *The Palgrave Handbook of Sociocultural Perspectives on Global Mental Health*. London: Palgrave Macmillan, pp. 211–35.

Campbell, C. and Burgess, R. (2012) 'The Role of Communities in Advancing the Goals of the Movement for Global Mental Health', *Transcultural Psychiatry*, *49*(3–4): 379–95.

Cohen, B. M. Z. (2016) 'The Psychiatric Hegemon and the Limits of Resistance', *Philosophy, Psychiatry, and Psychology*, 23(3): 301–3.

Das, A. and Rao, M. (2012) 'Universal Mental Health: Re-Evaluating the Call for Global Mental Health', *Critical Public Health*, 22(4): 383–9.

Davar, B.V. (2012) 'Legal Frameworks For and Against People with Psychosocial Disabilities', *Economic and Political Weekly*, 47(52): 123.

Davar, B. V. (2014) 'Globalizing Psychiatry and the Case of "Vanishing" Alternatives in a Neo-Colonial State', *Disability and the Global South*, 1(2): 266–84.

Desjarlais, R., Eisenberg, L., Good, B. and Kleinman, A. (1995) *World Mental Health: Problems and Priorities in Low-Income Countries*. New York: Oxford University Press.

Ecks, S. (2008) 'Three Propositions for an Evidence-Based Medical Anthropology', *Journal of the Royal Anthropological Institute*, 14(s1), S77–S92.

Environmental Protection Agency. (2016) 'Climate Impacts on Human Health', *Environmental Protection Agency*, https://www.epa.gov/node/153675/health.html (retrieved on 19 March 2017).

Fernando, S. (2014) *Mental Health Worldwide: Culture, Globalization and Development*. Basingstoke: Palgrave Macmillan.

Grover, S., Hazari, N., Singla, N., Chakrabarti, S., Aneja, J., Sharma, S. and Avasthi, A. (2016) 'Recovery Among Patients With Severe Mental Illness: Factor Analysis of Recovery Assessment Scale in Indian Setting', *Indian Journal of Social Psychiatry*, 32(2): 92–103.

The Holy Cross Centre Trust. (2013) 'Redefining "Services" for Social and Community Care', unpublished document.

Hovmand, P. S. (2013) *Community Based System Dynamics*. New York: Springer.

Jadhav, S. (2004) 'How "Culture Bound" Is "Cultural Psychiatry"?', *Indian Psychiatry*, 4: 6–7.

Jadhav, S. (2009) 'What is Cultural Validity and Why Is It Ignored? The Case of Expressed Emotion Research in South Asia', in van der Geest, S. and Tankink, M. (eds), *Theory and Action: Essays for an Anthropologist*. Diemen: Uitgeverij AMB, pp. 92–6.

Jadhav, S. and Barua, M. (2012) 'The Elephant Vanishes: Impact of Human–Elephant Conflict on People's Wellbeing', *Health and Place*, 18(6): 1356–65.

Jadhav, S., Jain, S., Kannuri, N., Bayetti, C. and Barua, M. (2015) 'Ecologies of Suffering', *Economic and Political Weekly*, 50(20): 13.

Jain, S. (2016) 'Cross-Cultural Psychiatry and the User/Survivor Movement in the Context of Global Mental Health', *Philosophy, Psychiatry, and Psychology*, 23(3): 305–8.

Jain, S. and Orr, D. (2016) 'Introduction: Ethnographic Perspectives on Global Mental Health', *Transcultural Psychiatry*, 53(6): 685–95.

Kirmayer, L. and Pedersen, D. (2014) 'Toward a New Architecture for Global Mental Health', *Transcultural Psychiatry*, 51: 759–76.

Klein, N. (2015) *This Changes Everything: Capitalism vs the Climate*. New York: Simon and Schuster.

Kleinman, A., Das, V. and Lock, M. (eds) (1997) *Social Suffering*. London: University of California Press.

Lancet Global Mental Health Group. (2007) 'Scale Up Services for Mental Disorders: A Call for Action', *The Lancet*, 370(9594): 1241–52.

Mendelsohn, R., Dinar, A. and Williams, L. (2006) 'The Distributional Impact of Climate Change on Rich and Poor Countries', *Environment and Development Economics*, 11(02): 159–78.

Mills, C. (2014) *Decolonizing Global Mental Health: The Psychiatrization of the Majority World*. London: Routledge.

Mills, C. and White, R. G. (2017) '"Global Mental Health Spreads Like Bush Fire in the Global South": Efforts to Scale Up Mental Health Services in Low And Middle-Income Countries', in White, R. G., Jain, S., Orr, D. and Read, U. (eds), *The Palgrave Handbook of Sociocultural Perspectives on Global Mental Health*. London: Palgrave Macmillan, pp. 187–209.

O'Hagan, M. (2004) 'Guest Editorial: Recovery in New Zealand: Lessons for Australia?', *Australian e-journal for the Advancement of Mental Health*, 3(1): 5–7.

Orr, D. and Jain, S. (2014) 'Making Space for Embedded Knowledge in Global Mental Health: A Role for Social Work?', *European Journal of Social Work*, 18(4): 569–82.

Patel, V. (2012) 'Global Mental Health: From Science to Action', *Harvard Review of Psychiatry*, 20(1): 6–12.

Patel, V., Minas, H., Cohen, A. and Prince, M. J. (eds) (2013) *Global Mental Health: Principles and Practice*. Oxford: Oxford University Press.

Patel, V., Collins, P.Y., Copeland, J., Kakuma, R., Katontoka, S., Lamichhane, J., Naik, S. and Skeen, S. (2011) 'The Movement for Global Mental Health', *British Journal of Psychiatry*, 198(2): 88–90.

Read, U. M., Adiibokah, E. and Nyame, S. (2009) 'Local Suffering and the Global Discourse of Mental Health and Human Rights: An Ethnographic Study of Responses to Mental Illness in Rural Ghana', *Globalization and Health*, 5(1): 13.

Rifkin, S. B. (2014) 'Examining the Links between Community Participation and Health Outcomes: A Review of the Literature', *Health Policy and Planning*, 29(suppl. 2): ii98–ii106.

Recovery in the Bin. (2016) 'RITB – 20 Key principles', *Recovery in the Bin*, https://recoveryinthebin.org/recovery-in-the-bin-19-principless/ (retrieved on 19 March 2017).

Rose, D. (2014) 'The Mainstreaming of Recovery', *Journal of Mental Health*, 23(5): 217–18.

Stavert, J. (2017) 'Mental Health Law in a Global Context', in White, R. G., Jain, S., Orr, D. and Read, U. (eds), *The Palgrave Handbook of Sociocultural Perspectives on Global Mental Health*. London: Palgrave Macmillan, pp. 329–49.

Summerfield, D. (2008) 'How Scientifically Valid is the Knowledge Base of Global Mental Health?', *British Medical Journal*, 336(7651): 992–4.

Swerdfager, T. (2016a) 'Politics and Mental Health', *Philosophy, Psychiatry, and Psychology*, 23(3): 309–11.

Swerdfager, T. (2016b) 'Theorizing Resistance: Foucault, Cross-Cultural Psychiatry and the User/Survivor Movement', *Philosophy, Psychiatry, and Psychology*, 23(3): 289–99.

Trani, J. F., Ballard, E., Bakhshi, P. and Hovmand, P. (2016) 'Community Based System Dynamic as an Approach for Understanding and Acting on Messy Problems: A Case Study for Global Mental Health Intervention in Afghanistan', *Conflict and Health*, 10(1): 25.

Transforming Communities for Inclusion: A Trans-Asia Initiative. (2013) 'Report: Transforming Communities for Inclusion of Persons with Psycho-Social Disabilities', *camhjournal*, https://camhjournal.com/advocacy/report-transforming-communities-for-inclusion-of-persons-with-psycho-social-disabilities/ (retrieved on 2 April 2017).

World Health Organization. (2001) *The World Health Report 2001: Mental Health: New Understanding, New Hope*. Geneva: World Health Organization.