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Guest Editors' Introduction

Unpacking Mental Health: Intersectionality-informed Approaches to Upholding Human Rights and Realizing Social Justice

MARINA MORROW
York University, Canada

GEMMA HUNTING
Simon Fraser University, Canada

SUSAN L. HARDIE
Eviance, Canada

A Crisis in Global Mental Health

> Never has it been so urgent for the world to prioritize mental health.
>
> D. Kestel, Director, Dept. of Mental Health & Substance Abuse, World Health Organization (World Federation for Mental Health, 2022, p. 2)

Conversations about mental health have become ubiquitous since the world experienced the COVID-19 pandemic.[1] Impacts of the outbreak and mitigation measures on mental health began to be highlighted by scholars, organizations, and governments, especially as populations emerged from long periods of isolation. Such impacts were tied to pandemic related stressors like food insecurity, economic adversity, and increases in gender-based violence as well as the overall mortality rate, all of which correlated with increased anxiety, stress, substance use, depression and suicide risk among the population, with health care workers, women and other disenfranchised groups generally more

[1] We recognize that the term "mental health" is contested because of the ways in which it has been used to reinforce reductive and medicalized understandings of human emotions and distress, including pathologizing and stigmatizing discourses of mental disorder and mental illness. In this introduction and in this volume, contributors use the language of "mental health" with this critical awareness and introduce other terms like "emotional distress" to describe similar phenomena.

Correspondence Address: Marina Morrow, School of Health Policy & Management, York University, 4700 Keele St., Toronto, ON M3J 1P3; email: mmmorrow@yorku.ca

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effected (Dailey et al., 2024; European Commission [EC], 2022; Gadermann et al., 2021; Letourneau et al., 2022; Martínez et al., 2021; Panchal et al., 2023; Porter et al., 2021; Sher, 2020; United Kingdom Government, 2022; World Health Organization [WHO], 2022a, 2022b). Although researchers have debated whether the pandemic worsened population mental health overall (e.g., Aksunger et al., 2023; Cost et al., 2022; Findlay et al., 2020), the broader policy narrative at the state and international level was that of a global mental health crisis (e.g., Baird et al., 2020; Government of Canada, 2021; Organisation for Economic Co-operation and Development, 2021; Schwartz, 2024; WHO, 2022b). This crisis, and the urgency of comprehensive policy solutions continue to be underscored around the globe (e.g., Fitzgerald et al., 2024; Kotwal, 2022; Patel et al., 2023; Suetani et al., 2024).

At the same time, greater attention has been paid to societal inequities that became more publicly visible and amplified during the pandemic, and have worsened in its aftermath (e.g., Ahmed et al., 2022; Asian Development Bank, 2020; British Medical Association, 2022; The Kings Fund, 2024; McGrail et al., 2022; United Nations Development Programme, 2024; Yonzan et al., 2023). Soaring interest rates as countries have struggled to come out of the pandemic and the rising costs of housing and food in many countries, have been exacerbated by global shocks and disruptions, from wars to the global migrant crisis, to climate emergencies. The political shift to the right in many countries has ushered in political regimes that favour the rights of corporations over citizens and indeed over the health of the planet. These politics have exacerbated the gap between the rich and the poor, contributed to a rise in xenophobia, polarization, discrimination and hate crimes, and furthered inequities (e.g., Farinelli, 2021; United Nations [UN], 2023). Such developments and their interactions are recognized as profoundly impacting emotional and social well-being across populations, particularly for groups who experience multiple and systemic forms of oppression. The need to address such oppression has been increasingly emphasized in academic, policy and activist discourse (e.g., Ince & Dunivin, 2022; Kimani, 2023; Rejali, 2020).

Persisting Inadequacies in the Status Quo for Mental Health

The COVID-19 era has importantly catalyzed increased calls and commitments to strengthen mental health care and implement new policy interventions in ways that serve diverse communities. However, despite this increased focus, few (if any) initiatives have addressed mental health beyond a psychiatric and biomedical model of care, a model increasingly critiqued as overlooking the complex contexts shaping mental health. As this issue will highlight, this has grave implications for how mental health is understood and the kinds of supports available to people, especially those experiencing

interacting forms of inequity. Solely upholding a biomedical model of mental health has masked the historic and current social, political, and economic contexts in which mental health and well-being are embedded, thus impeding truly impactful interventions that account for and address factors including discrimination, poverty, violence, and homelessness (Morrow & Halinka-Malcoe, 2017; Wicklund et al., 2021, forthcoming).

It is important to note the significant role that neoliberal political regimes have played in upholding a biomedical model of mental health, helping shape dominant individualistic understandings of the relationship between emotional distress, health, mental health and mental health system initiatives (Morrow, 2013, forthcoming; Polzer & Power, 2016). In policy, for example, neoliberalism discursively reinforces individualistic understandings of social issues such as poverty and substance use as caused by poor choices (Luxton & Braedley, 2010; Smith et al., 2008). Correspondingly, neoliberal approaches tend to construe social problems as inherent among certain populations, resulting in the conflation of social locations (e.g., gender, sexual orientation, migrant status) with individual "risk" characteristics that require individual rather than social and systemic interventions.

The impact of neoliberal ideologies on mental health systems and policies was further highlighted during the COVID-19 pandemic, exposing the inadequacies of systems that are difficult to access, fractured, and persist in framing mental health relevant issues as solely biological, despite much evidence to the contrary (e.g., Beals et al., 2021; Card & Hepburn, 2023; Giles & Hughes, 2023; Moncrieff et al., 2023). Biomedicalism and neoliberalism have long been recognized in critical research as contributing to the rampant medicalization and "diagnosis" of every possible human emotion and experience thus producing new forms of subjectivity and governance that profoundly shape our lives (Rose, 1989, 1996, 2006). It is thus critical that such systems and processes of power are confronted to better bring attention to the social and structural contributions to emotional and mental distress as well as actions to address them (Morrow, 2017; Wicklund et al., forthcoming).

Embracing a Paradigm Shift

Critical feminist thought, including postcolonial, intersectional, and Black feminist theories and methodologies (e.g., Collins, 1990, 2007; hooks, 1984; Tuhiwai Smith, 1999), have been crucial in understanding how we perceive and experience social, structural and historical factors, including how we understand our social positions relating to mental health care and other systems and institutions that have been shaped by power hierarchies including (settler) colonialism and neoliberalism. This awareness has also been led by and informed by activism emerging from communities marginalized through multiple and intersecting forms of oppression, including sanism (e.g., Combahee River Collective, 1977; Deegan, 1988; Ingram, 2008). As

academics and community-based advocates we are differentially positioned in this work but share a concern about widening inequities globally and the ways in which emotional and mental well-being are increasingly being medicalized and pathologized and the implications of this for people's lives and for mental health research, policy and practice.

It is in this context that we believe it is essential to embrace a paradigm shift in how we talk about mental health and in how we act. Specifically, what is required is critical reflection and discourse on how mental health is inextricable from our social, historical, political, and economic conditions, as well as how health systems, medicine, and the "psy" professions have developed and operated in alignment with the aims and goals of colonialism, imperialism, and other interlocking systems of oppression (Eromosele, 2022; Ibrahim & Morrow, 2015; Morrow & Halinka-Malcoe, 2017; Richardson, 2020; Wispelwey et al., 2023). This has fostered a deep mistrust of mental health care systems, including among Black, Indigenous and people of color, resulting in further barriers to well-being and care (Dailey et al., 2024; Espinoza-Kulick & Cerdeña, 2022; Millner et al., 2021; Rhodes & Langtiw, 2018). These facts – though increasingly discussed in recent years – have not been fully interrogated, resulting in practitioners often unwittingly participating in systems that reproduce relations of power and domination.

There is also need for community-informed and led action to promote human rights and address historical and current forms of marginalization. In our cumulative years working to address health inequities, including mental health inequities, we have often witnessed a disjuncture between what is discussed or called for in high-level forums, and what is practiced on the ground. Beyond high level commitments to mental health system reform, there must be *action* towards the promotion of equity and rights within and beyond the system itself. Doing this requires a commitment to mobilizing diverse forms of knowledge and participation in policy and research processes, prioritizing the input and leadership of communities themselves. It also requires cross-disciplinary and cross-sectoral work to help ensure the complexities of mental and emotional distress, and the solutions to promote mental health are meaningful and beneficial to all.

Many promising community embedded practices exist globally that respect human rights and human dignity in the context of providing resources and supports in mental health (Human Rights Watch, 2023; Morrow & Hardie, 2014; Wicklund et al., 2021, forthcoming; WHO, 2021). In line with other critical mental heath and Mad scholars and community activists (e.g., Beals et al. 2021; Beresford & Russo, 2022; Daley et al., 2019; Morrow & Halinka-Malcoe, 2017), we believe that social justice-oriented approaches to mental health research, policy, and practice, informed by intersectional and decolonizing approaches, offer powerful foundations to counter the status quo and facilitate the time and space to co-create and realize social change.

Intersectional and Decolonizing Approaches

Intersectionality has long historical roots in the activism of Black, Indigenous, queer and women of colour in both the Global North and South who fundamentally understood that oppressions such as patriarchy could not be dismantled without reference to other mutually constitutive systems of power including racism, ableism, colonialism and imperialism (Bilge & Collins, 2016; Combahee River Collective, 1977; Hancock, 2016; Hardie et al., 2018; hooks, 1984; Hull et al., 1993; Mohanty, 2003; Torres et al., 1991). Intersectionality is variously defined but can be said to encompass a few key principles, including the idea that social categories and identities are intersecting and overlapping, attention to understanding how power operates through social and structural processes, respect for diverse knowledges, attention to equity, resistance and resilience as integral to disrupting power and oppression, and that advantage and disadvantage are not static but change across time and space (Hankivsky et al., 2014). In addition, intersectional scholarship and community activism must be engaged in reflexively, that is with critical reflection of one's own social position within broader power dynamics and its impact on assumptions, beliefs, and practices (Hankivsky et al., 2012; Hardie, 2009). Further, social justice aims are central to intersectional approaches, which strive to better understand how oppression operates and attempts to create substantive social and structural change (Hankivsky et al., 2012). While such principles have long been integral to social justice activism, intersectionality is widely recognized as an innovative and necessary approach to research, policy and practice, to capture and respond to the complexities of health and social issues (e.g., Abrahms et al., 2020; Borras, 2021; Hankivsky & Jordon-Zachary, 2019; Morrow & Hardie, 2014; Robert Bosch Stiftung, 2023; Scottish Government, 2022; Windsong, 2018).

In the context of mental health research, scholars have taken up intersectionality in diverse ways. For example, an intersectional approach has been used to better understand the ways in which intersecting forms of discrimination impact mental health and access to mental health services (e.g., Hempeler et al., 2024), as an analytic lens to understand how the intersections between stigma and discrimination in mental health are mediated by factors including age, gender identity, racism, racialization and migration processes (Hunting et al., 2015; Morrow et al., 2008b, 2019), as a way to document the harmful impacts of intersecting forms of discrimination on mental health (e.g., Trygg et al., 2019), and as a theoretical framework in mental health to surface how power operates in psychiatric systems and the implications of this for people's lives (e.g., Cole, 2009; Cole & Duncan, 2023; Morrow & Halinka-Malcoe, 2017; van Mens-Verhulst & Radtke, 2008; Wicklund et al., 2021, forthcoming). Researchers, community activists, and Mad activists have argued that sanism be considered as a set of organized and systemic practices of oppression that operate in an interconnected way with forces including

racism, sexism, heterosexism, ageism, and ableism, thus expanding the ways in which intersectionality is used (Gorman, 2013; Ingram 2008, 2016; Morrow, 2017; Redikopp, 2021; Tam, 2013).[2]

In relation to mental health policy, intersectionality has been reluctantly and inconsistently taken up by the Canadian state but is beginning to be embraced by some community-based advocacy and disability rights organizations (Canadian Mental Health Association [CMHA], 2019, 2024; Eviance, 2024; Hardie et al., 2018). Notably, intersectionality was discussed and advocated for during the development of the first mental health strategy in Canada (Mental Health Commission of Canada [MHCC], 2012), but never fully embraced. The strategy was never implemented, contributing to a significantly broken and fragmented mental health care system. However, a recent cross-national needs assessment recommends that intersectionality be taken up as a key analytic concept for guiding mental health policy processes and embedding in mental health organizations (MHCC, 2023). And, at an international level, intersectionality is increasingly discussed as an important concept for understanding mental health and strengthening mental health relevant policies (e.g., Laval et al., 2023; LGBTIQ+ Health Australia, 2021; Mental Health Europe, 2024; WHO, 2023).

Yet despite the increased recognition of intersectionality's importance within and beyond the mental health field, it is often discussed (particularly in policy) in ways that are "watered down," specifically by overlooking its core principles, including its attention to power and its social justice imperative (Bastia et al., 2022; Hunting & Hankivsky, 2020). Indeed, much has been written about the ways in which intersectionality has been co-opted, bureaucratized, and depoliticized by, for example, conflating an intersectional approach with attention to multiple identity categories without attention to structural power dynamics both within and outside of policy processes (Bilge, 2013; Moradi & Grzanka, 2017; Tripp, 2023; Warner et al., 2020). As such, the community and academic activist roots of intersectionality must always be acknowledged,[3] and careful stewardship of its underlying principles including attention to power and valuing diverse knowledges is needed to realize its social justice imperative in policy, research, and practice (Cole, 2020; Hancock 2016; Hankivsky & Jordan-Zachery, 2019; Jordan-Zachery, 2007).

In our view, decolonizing approaches are necessary to prevent this watering down of intersectionality and ensure its transformative potential. Decolonizing approaches allow for sufficient attention to be paid to sociohistorical systems

[2] Sanism is a concept used to describe the particular ways in which people are discriminated against based on mental illness diagnoses or on expressed behaviours that are outside of social norms (e.g., Ingram, 2011; Poole et al., 2012; Poole & Ward, 2013). The concept of sanism bears much resemblance to Judy Chamberlin's concept of "mentalism" (see Chamberlin, 1975).

[3] For more on the evolution of intersectionality from its early beginnings to current applications, and the concept of stewardship, see Ange-Marie Hancock's *Intersectionality: An Intellectual History* (2016).

and structures – and, in particular, colonial (and settler colonial) structures from the global to the local – in any analysis or policy process. We see decolonizing frameworks as sitting nicely alongside intersectionality for what they can tell us about the (often overlooked) relationship, both historical and present, between oppression and mental health, and between experiences of emotional distress, mental health systems, psychiatry, and colonization (Warner et al., 2020). Decolonizing approaches, like intersectionality, centre the lives and experiences of oppressed populations, consider structural and systemic forms of power, and value local and traditional knowledge systems (e.g., Ibrahim, 2017; Rivera-Segarra et al., 2022).

However, it is important to recognize tensions between intersectionality and decolonizing approaches, particularly given that a principle of intersectionality is allowing for relevant experiences of oppression and privilege to be revealed in any given analysis rather than decided on *a priori*; whereas decolonizing approaches centre the effects of colonialism. There is also debate about the use of intersectionality for understanding Indigenous lives, particularly since many Indigenous activists and scholars centre colonization as the *a priori* form of oppression to be challenged and interrogated. However, in much research, policy, and practice claiming to be intersectional, colonialism as embedded in transnational, historical and ongoing processes has not been given sufficient attention. This is illustrated, for example, by the amount of research and policy practice claiming to be intersectionality-informed and focused on issues that impact Indigenous populations that has reinscribed colonial harms by failing to be driven by or centred on Indigenous leadership, community contexts, methods, or knowledge systems (Findlay, 2019; Sanchez-Pimienta et al., 2021). However, recent years have seen an increase in critical work that takes up intersectionality productively to address the complexities of colonialism and decolonize research and policy processes including by Indigenous and Global South scholars and activists (e.g., Clark's (2016) use of "red intersectionality"; Becker, 2023; Blackdeer, 2023; Levac et al., 2018; Narayan & Morales, 2023; Native Women's Association of Canada, 2020; Women of the Métis Nation, 2019).

Psychiatric Deinstitutionalization, Mental Health Law and Human Rights

To set the stage for contemporary mental health policy and practice discussions it is important to understand how systems have evolved and the central role that deinstitutionalization and mental health law have played in shaping much of the response to mental health in both the Global North and South. Here we highlight a few key reforms.

In North America, Europe and Australia, large psychiatric institutions started to be closed from the 1970s onwards in favour of shorter term stays in psychiatric wards of hospitals and care in the community. Although there were

multiple factors influencing this deinstitutionalization, a key idea behind it was that care in the community anchored in recovery models would support and empower people living with mental distress to live fulfilling lives (Deegan, 1988; MHCC, 2012; Morrow, 2013).[4] However, in most jurisdictions, people leaving psychiatric institutions either languished in the community without adequate supports or were re-institutionalized in regional hospitals or through the criminal justice system (Boschma et al., 2014; Dear & Wolch, 1987; Montenegro et al., 2023; Morrow et al., 2008a, 2011), often placing higher burdens of care on families and friendship networks.

With deinstitutionalization came the strengthening of mental health laws that allow physicians and police to involuntarily detain and treat people, and the use of mechanisms, like community treatment orders, which while designed to ensure community safety often function to control the behaviour of people once they leave hospitals, mostly through monitoring medication compliance (Brophy et al., 2018). Some of the abuses that psychiatric hospitals are known for have simply been transferred to regional psychiatric hospitals and to care in the community. For example, in addition to involuntary detainment and treatment being legal under mental health acts it is still common practice in many jurisdictions to restrain people physically or chemically through the use of pharmaceuticals and to subject people to dehumanizing practices such as strip searches and isolation rooms in the context of psychiatric care (Brophy et al., 2016; Edan et al., 2019; Põras, 2017). These practices continue undocumented and without oversite, despite international human rights treaties that many countries have signed (e.g., UN Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, 1984; United Nations Convention on the Rights of Persons with Disabilities, 2006; UN Declaration on the Rights of Indigenous Peoples, 2007).

Many of the people in emotional distress who we see on city streets today throughout North American and Europe are indeed part of this deinstitutionalization legacy, however, decisions by neoliberal governments in many jurisdictions to reduce funding to social services and to shape policy in ways that makes it more difficult to access supports for housing and income security have had the greater impact (Morrow et al., 2006, 2009; Skull, 2021). In the wake of increased homelessness and poverty in many North American cities (made worse by the ravages of the opioid crisis) we have seen

[4] Recovery models emerged originally out of the activism of people with lived experience of psychiatry, who challenged the long-entrenched belief by the psychiatric profession that people with diagnoses of mental illness could not live full and productive lives (see Deegan, 1988). Since then, recovery has been defined in myriad ways (Anthony, 1993; Markowitz, 2001; Ramon et al., 2007), however, its contemporary usage in policy is distilled in the definitions provided by the Mental Health Commission of Canada (2009; 2012). In their framework for a mental health strategy, they describe recovery as "…a journey of healing that builds on individual, family, cultural and community strengths, and enables people living with mental health problems and illnesses to lead meaningful lives in the community, despite any limitations imposed by their condition" (MHCC, 2009, p. 8).

governments double down on policing and coercive measures which include involuntary detainment by psychiatrists to deal with upticks in public demonstrations of distress and the overwhelming number of people who are sleeping on public transit, in tents or on city streets (e.g., Newman & Fitzsimmons, 2022).

While psychiatric deinstitutionalization is considered a global standard (UN, 2022) in much of the Global South mental health care is still provided through hospitals and in-patient settings, or more informally through spiritual and traditional healing (Fernando, 2019). Instead of building local community infrastructure and supports that are relational, holistic and aligned with human rights and social justice, western psychiatric models have been imported throughout countries of the Global South (Ibrahim, 2017; Mills, 2014, 2017). The wholesale adoption of western models of psychiatry has undermined local healing practices and knowledge systems and perpetuated colonial practices of western medical imposition onto populations (Ibrahim & Morrow, 2015; Mills, 2014; Summerfield, 2013). Even the Sustainable Development Goals, much lauded for including mental health (see Thornicroft & Votruba, 2018) as well as for considering the broader determinants of well-being and development, have largely adopted a biomedical framework for understanding mental and emotional distress (UN, 2015).

These global trends are undermining decades of individual and collective activist work that has been done by people who have direct personal experience of emotional distress and who are calling for systems that are caring and compassionate rather than coercive and damaging (Beresford & Russo, 2022; Burstow et al., 2014; Daley et al., 2019; Davar & Bhat, 1995; Eromosele, 2022; Iga, 2022; Kilty & Dej, 2018; Morrow & Halinka-Malcoe, 2017). For these reasons we need to bring social justice back into the conversation about mental health.

This Issue

In this issue we feature pieces by authors who, like us, share a common concern with the ways in which psychiatry and other intersecting structures and processes shape oppressive responses to mental health and emotional distress, with a focus on policy, human rights, the law and social justice. The articles focus on work emerging in the context of Canada, Kenya and Australia - all countries with distinct histories of colonization and all countries that share the same mental health legislative framework in British common law.[5] Canada,

[5] Some of the pieces emerged from the work of the *Realizing Human Rights and Social Justice in Mental Health* project (www.socialjusticeinmentalhealth.org). This research is a partnership between academics and community-based disability rights organizations in Canada, Kenya and Australia and is funded by a SSHRC Insight Grant (2020-2024). The research is investigating the ways in which human rights and equity can be optimized through community-based mental health services, policy, resources and supports.

Kenya and Australia are all signatories to the UN Convention on the Rights of People with Disabilities (CRPD) (2006),[6] and yet many of the routine practices of mental health care in these countries violate the Convention (Brophy et al., 2018; Newton-Howes, 2019; Newton-Howes & Ryan, 2017; Põras, 2017). The authors of the pieces in this volume work from the values found in intersectional activism and practice, particularly, through the honoring of lived experiences of emotional distress and experiences of colonization and through their efforts to unpack dominant biomedical discourses that pervade mental health policy and practice. The result is a set of articles that both critique current policy and practice and offer new ways of conceptualizing and responding to the diversity of emotional and mental distress. This is done through reimagining what support can look like in humane systems co-created by people with lived experience, that allows people to retain their dignity and human rights.

To open this series, we begin with, Jonard, Cohen, Ibrahim and Hegarty's piece, "Storywork to Decolonize Mental Health: Recentering Indigenous Histories in Canada, Kenya and Australia" (2024, pp. 399-417). This piece uses the Indigenous practice of storytelling as a decolonizing tool for exploring the ways in which the colonial histories of Canada, Australia and Kenya are integrally bound up in the development of psychiatry and mental health practices and how colonial practices have served to reinscribe power relations which disproportionately impact Indigenous communities. The authors ground their discussion of colonialism in specific stories from each region to which they have a personal connection, to elucidate how colonialism intersects with psychiatric systems and practices. In including story telling, a powerful Indigenous practice, in this collection and subjecting it to Eurocentric norms of peer review we recognize the contradiction this embodies. However, we understand decolonization as an ongoing process and that bringing stories of colonization and Indigenous ways of knowing into academic scholarship in ways that honor Indigenous and non-Indigenous collaboration are vital to this process.

In the next piece, "Challenging Involuntary Treatment and Confinement in Canada through the United Nations Convention on the Rights of Persons with Disabilities (CRPD)" Rozinskis and Rourke (2024, pp. 419-439) use Canada as a case study to contrast the intended goals of the CRPD with the current legislative reality of domestic mental health law and the use of forced psychiatry. Through conversations with disability rights activists, they focus on the role that disability rights organizations have played in pressuring their respective governments to sign on to the CRPD and to monitor mental health

[6] Note that Canada and Australia signed on to the UNCRPD with Reservations to Article 12 which means that they can continue to allow substitute decision making in the context of mental health care. Kenya has no reservation and Canada and Australia have also signed on to the CRPD Optional Protocol. Also note that both Canada and Australia have also signed on to the UN Declaration on the Rights of Indigenous peoples.

practices to ensure compliance with international human rights treaties. They argue that psychiatric interventions do more harm than good and are an outdated medical practice. Further, they demonstrate that there is a growing body of evidence that shows that people can be supported in ways that respect their rights without having to resort to mental health legislation.

The next set of four articles provides an analysis of local mental health policies in Canada (Ontario and British Columbia (BC)), Australia (Victoria) and Kenya using elements from the Intersectionality-Based Policy Analysis Framework (Hankivsky et al., 2012). These analyses illustrate the ways in which underlying values and assumptions influence policy discourses and reinforce dynamics of power including colonialism, biomedicalism and neoliberalism in ways that converge to exclude and marginalize, reinforce stigma and discriminatory practices, privilege certain systems of knowledge and tacitly sanction human rights violations. The first two papers address the Canadian context, illustrating the ways in which domestic mental health policy differs between jurisdictions. In "British Columbia's Mental Health System: Addressing Systemic Human Rights Issues" Josewski, Morrow, Warkentin, Ibrahim and Cohen (2024, pp. 440-460) show how tensions between calls for practices that restrict human rights and those that are rooted in equity and social justice in mental health have shaped the BC mental health landscape. They interrogate the effects of a biomedical and individualized framing of mental health and substance use and argue that such framings are buttressed by neoliberal ideology laying the groundwork for public and professional acceptance of coercive practices with specific consequences for Indigenous populations. They juxtapose this framing with a holistic wellness and trauma-informed policy framework emerging from BC's First Nations Health Authority which is anchored by an understanding of the impact of colonization. They conclude that while the latter framing is much more in line with decolonial understandings of mental health, both policy directions fail to fully account for ongoing human rights violations under BC's Mental Health Act.

Cohen, Morrow and Rawson's (2024, 461-480) "Mental Health Care and Policy (In) Justice in Ontario: Making Intersections Visible" similarly uses the Intersectional-Based Policy Analysis Framework (Hankivsky et al., 2012) to explore tensions in mental health policy and to identity contextual influences, including underlying values and assumptions, which promote or undermine the uptake of human rights and equity as a mental health policy priority in Ontario. They track key historical moments in Ontario's mental health reform, policy and law and show how dominant framings of the "problem" of mental health (as lack of access, lack of coordination/integration, as a fiscal drain, as an economic burden, and as a clinical or medical problem) have served to ignore the underlying social and structural conditions that impact mental health and the human rights violations that routinely occur in the context of "care." They make visible how underlying power structures and the apparatus of managerialism in Ontario mask the experiences of people marginalized through structural oppression. They conclude by focusing on the community

activism and responses of those seeking justice in the context of police murders of Black, Indigenous and people of colour in Toronto, Canada, that are striving to address racism and colonialism in mental health, illustrating how community-driven responses can engender practices that align with human rights and equity.

In another paper that focuses on the Ontario context, "Interrogating Safeguards Under the Mental Health Act (2000) in Ontario: Towards a Postmodernist Relational Understanding of Disability" Han (2024, 481-498) utilizes a critical discourse analysis to deconstruct how the concept of mental illness is deployed in an important legal case (Thompson and Empowerment Council v. Ontario, 2013) brought against the Mental Health Act. The case was not ruled in favour of the complainant who charged that Community Treatment Orders under the Mental Health Act are a violation of Canada's Charter Rights. Drawing on Foucault's concept of biopower, Han shows how mental illness is mobilized in legal discourse through a clinical lens, reinforcing psychiatric definitions and notions of "dangerousness." Han suggests that a postmodernist relational concept of disability could be used as an alternative legal tool to unsettle medico-legal power.

Rawson, Zirnsak, Di Pierdomenico, Edan and Brophy (2024, pp. 499-514) in "Access and Injustice: An Intersectional Analysis of Victorian Mental Health Policy in Australia" look at key mental health policy documents in Victoria to surface the ways in which policy obfuscates how social positioning based on race, socioeconomic status, and gender influences the degree to which people will experience compulsory treatment. That is, only social determinants that impact mental health outside of the mental health system tend to be considered, to the exclusion of considering the system itself. This oversite allows the damage that compulsory treatment has on poor and racialized communities to go unacknowledged, illustrating how engrained discrimination is within the mental health care system.

Di Pierdomenico, Kamau, Ibrahim, Njenga, Morrow and Warkentin (2024, pp. 515-532) shift the focus to the global south in their analysis of national mental health policy in Kenya. In "Mental Health in Kenya: Tensions Between Human Rights Approaches and Colonial Care" they describe mental distress as something that is subject to entrenched stigma and discrimination at multiple societal levels. They explore policy discourses in national policies and illustrate how a default to western biomedical solutions for addressing mental distress dominate institutionally and in practice. Western biomedical framings serve to marginalize local community-based responses that are grounded in Kenyan cultural traditions. They urge the Kenyan government to abolish coercive mental health practices, remove systemic barriers that hinder participation, and establish supports to empower people with psychosocial disabilities and their organizational representatives to ensure mental health responses are consistent with international human rights treaties.

In the final piece in this issue, Redikopp, like Han, employs discourse analysis. Redikopp's piece, "Risk, Surveillance, and Harm: Towards an Intersectional Social-justice Framework for Engaging Self-harm" (2024, pp. 533-551) examines the discursive construction of youth self-injury as "risk" in mainstream news articles in Canada through a neoliberal governmentality framework. Redikopp argues that self-injury risk discourses are consistent with neoliberal mental health paradigms, which individualize and depoliticize distress while making individuals responsible for their own recovery and wellbeing. Ultimately, Redikopp argues that the construction of self-injury in terms of risk frames self-injuring youth as failed neoliberal subjects. Reductive risk discourses are therefore incompatible with social justice paradigms in mental health.

Taken together, the papers illuminate how current legislation, policy and practice contribute to ongoing social and structural inequities, and how social activism and intersectional and decolonizing frameworks can work to transform this towards a path of social justice to realize a global society that fosters emotional health and well-being.

No longer can we allow conceptions of and responses to mental health to be dominated by clinical and biomedical approaches which ignore the complex contexts of people's lives. Too much evidence about the dynamics between the multi-level conditions of people's lives and emotional distress has been amassed for governments to continue to reinforce narrow understandings and treatment of mental health while ignoring the obvious interconnections between mental health and people's social conditions (Beresford & Russo, 2022; Morrow & Halinka-Malcoe, 2017; WHO, 2021). Reductive problem framing and top-down approaches not informed by the communities impacted, especially those that have been historically excluded from decision making, has led to inadequate responses that have arguably worsened mental health inequities. Emotional health and well-being require conditions of trust and non-discriminatory care and broad cross-sectoral approaches where human rights and dignity are respected.

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