

Tears, traditions, and transformations

**Tears, traditions, and transformations:  
Decolonizing mental health through community healing**

*Khushi Ahuja*

**Bio Note**

Khushi Ahuja is a trainee counsellor pursuing her MSc in Psychological Counselling at Bangalore University. With a strong foundation in sociology and psychology, she explores mental health as a deeply personal and profoundly social experience. Her academic and professional interests lie in counselling, forensic psychology, and community-based mental health systems that prioritize accessibility and cultural relevance.

Khushi's work is rooted in an interdisciplinary approach bridging theory, lived experience, and systemic critique. She has presented her research at national and international forums, speaking on themes such as digital patriarchy, emotional labor, and community mental health interventions.

Her commitment lies in building mental health ecosystems that are empathetic, inclusive, and socially aware. She believes in reimagining care through collective practices, honoring indigenous knowledge, and evolving clinical frameworks.

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## Abstract

Psychology as a discipline has often been viewed as a neutral scientific discipline. However, it has been criticized for having a colonial legacy, with Western-centric theories and practices being imposed on non-Western cultures, which has been impacting mental health understanding and treatment in the country. Neoliberal privatization and colonization have systematically marginalized the indigenous knowledge and erased indigenous healing traditions, leading to already existing inaccessibility and unaffordability of mental health care. Therapy has become an elite privilege rather than a universal right due to the market-driven nature of modern mental health. This paper intends to explore the potential for a community-based crisis intervention system as an integrative approach to mental health care, focusing on state-supported models that can improve accessibility and affordability, reduce stigma, and bridge existing gaps by making it more culturally relevant.

This study reviews global examples of community-based and decolonial mental health interventions and India's Atmiyata programme in Gujarat. This volunteer service identifies and supports people experiencing distress in rural communities. This paper critiques the neoliberal commodification of mental health, where therapy is marketed as an individualistic, privatized service rather than a social responsibility. It examines the state's responsibility in making mental health more accessible and affordable mental health services amid diminishing public health provisions. It emphasizes the potential benefits of a community-driven, state-supported intervention system, integrating it with reclaiming traditional healing practices. This paper further argues that integrating social and behavioural sciences at the community level could significantly enhance mental health outcomes and foster psychoeducation. The findings highlight the urgent need for decolonizing mental health by prioritizing affordable, grassroots interventions. This paper informs policy and future research to create pragmatic interventions and an inclusive mental health ecosystem integrated with local knowledge pools and collective healing.

Keywords:

*Accessibility; decolonization; affordability; community-based intervention; scalable setups; psychoeducation; traditional healing*

## Introduction

One of humanity's core wounds is colonialism; it has a vast and profound ripple effect that often goes unnoticed. When a wound goes unnamed, unattended and unnoticed, it grows and festers, eventually infecting everything around it. Fanon (1963) and Quijano (2000) posited that colonialism is not merely a historical phenomenon but a living framework that continues to inform mental, political, and spiritual realities. It calls for a halt to pathologizing and individualist Eurocentric models of well-being that do not recognize those who have been historically overlooked and deliberately marginalized. It requires a model of mental health that is accessible to all and offers a path to emancipation and well-being.

Although this paper does not take on an extensive theoretical examination of postcolonial studies, it is situated within important ideas in thinkers like Partha Chatterjee, Gayatri Chakravorty Spivak, and Boaventura de Sousa Santos. Their discussions of colonial knowledge production, epistemic violence, and structural exclusion contextualize this investigation. Specific. Santos's theory of epistemic systematic erasure of indigenous knowledge systems in the name of modernity frames the marginalization of local healing practices in India's psychiatric landscape.

Mental health care in India remains a privilege rather than a right; it stands to be a lifestyle, not a public health service, as millions continue to struggle with the high cost, inaccessibility, cultural bias and deep-rooted stigma. The existing system lacks structure, has resource constraints, an implementation gap and a lack of necessary education and awareness. There exists a huge stigma, a shortage of qualified mental health professionals, and urban-rural disparities and cultural barriers, making mental health care practically impossible to access. While the country has made strides in policy and awareness, the existing system is far from adequate in addressing mental health issues and providing mental health care, especially to underserved communities.

Decolonizing mental health means stripping away Eurocentric models which pathologize non-Western forms of being, and replacing them with culturally rooted, community-led conceptualizations of well-being. Mental health care in India is at a strange crossroads, stretching

between two different worlds. One is the glossy, individualized world of private therapy, expensive, culturally urban and often inaccessible to the majority; the other, deep-rooted traditions of collective healing, community care, and wisdom derived from Indigenous roots, one that is treated as an esoteric phenomenon.

Colonial legacies remain deeply rooted in how mental health and care are understood and dealt with in India. Western-centric frameworks have often disregarded local realities, eroding Indigenous practices that served as vital forms of psychosocial support. Simultaneously, neoliberal commodification and privatization have further marginalized public mental health services, transforming them into an elite privilege rather than a universal right. The entire discipline of psychology has become an elitist one, where internships, training and education itself are designed for the upper middle class, making the grassroots of MHP unaffordable.

Mental health care is not unaffordable merely because it is "Western." It is unaffordable because the neoliberal state outsourced health care to private actors and keeps mental health in check with licensure monopolies that shut out people at the grassroots level.

What does a mental health intervention system that is true of and for the people look like? A system that holds space for collective grief and healing, one that honors cultural knowledge and moves beyond neoliberal commodification and clinical models that dominate the current discourse.

This paper is not about eradicating Western psychology, considering the contributions of the greats (or, as we call them, that) are welcome efforts to delve deeper into the mysteries of the mind. Instead, it invites a creative fusion between the Indian psychological traditions and the newer Western methodologies. It explores the possibility of transformation, arguing for a more integrative, grounded approach, weaving together formal and informal care, learning from traditions instead of dismissing them. This can help build an ecosystem of healing that is culturally relevant and resonant, accessible and affordable. This paper positions the mental health care crisis within the overlapping paradigms of biopolitics, epistemicide, and market fundamentalism. It presents a decolonial praxis informed by collective care, state accountability, and epistemic justice. To ignore an individual's lived experiences and systemic oppression is to call mental health care inefficient and ignorant; well-being can be ensured through systemic change.

Tears, traditions and transformations are not a linear journey. It is a slightly idealistic yet pragmatic path worth exploring; if we are ever to reimagine mental health care that serves many and not just a select few, it is a path we must take. This paper critically assesses India's mental health infrastructure from a decolonial perspective using interviews, international models, and community interventions to offer an alternative and inclusive mental health system.

So, I ask you again, "What would a community-rooted, culturally resonant, decolonized mental health system look like?"

### **The Study**

**Research Design:** This study employs a qualitative, critical-interpretive research approach based on decolonial theory. It takes up an epistemology that questions colonial, casteist, and neoliberal configurations of mental health care. The aim is descriptive and transformative, attempting to suggest system alternatives based on community, cultural knowledge, and epistemic justice.

**Data Collection:** Primary data were gathered via semi-structured interviews with three important stakeholders across the Indian mental health landscape:

1. A government counsellor at a university working at the grassroots level of education
2. An Assam student who is finding her way around access to therapy through cultural and economic impediments
3. The director of Earth Saviours Foundation, an NGO that works with abandoned and severely mentally ill individuals through community care

The interviews were face-to-face and online, verbatim transcribed, and thematically analyzed. The narratives provide institutional critique and personal insight, enabling the research to draw from lived experience at varying socio-economic locations.

Aside from interviews, the study incorporates secondary data through a comprehensive literature review of scholarly publications, policy documents, and case studies across Indian and global mental health models. Examples include Brazil's CAPS, Kenya's USP-K, and India's Atmiyata initiative. Together, these sources form a multi-scalar, comparative analysis of mental health systems.

**Analytical Approach:** The analysis used a critical thematic framework, borrowing from decolonial and postcolonial theory to spot patterns of exclusion, epistemic violence, and possible resistance within India's existing mental health landscape. The interview transcripts were inductively coded, but also plotted against major concepts like epistemicide (Santos), biopolitics (Foucault), necropolitics (Mbembe), and subalternity (Spivak).

By integrating first-person accounts, international best practice, and theoretical critiques, the paper seeks to build a different community-based care model based on priority given to access, dignity, and cultural relevance over clinical abstraction and neoliberal effectiveness.

## **Wounds to Wisdom: Journey of Decolonizing care**

### **1. Colonial Legacies and the Marginalization of Indigenous Knowledge**

Colonialism did not just take the land; it discredited entire ways of knowing. It functioned as an epistemic conquest that imposed hierarchies of knowledge. The Western colonial state introduced psychiatry as a civilizing project; we already had psychology. Although grounded in a Eurocentric framework, psychology had already existed in the Upanishads and Buddhist teachings, but were systematically dismissed as unscientific; it was not because they were unscientific or lacked rigor, but because they threatened the universality of Western Enlightenment rationality. Systems like Ayurveda, Yoga, Sufi healing, and Buddhist mindfulness. While movements such as Bhakti provided accessible modes of affective expression and bodily spirituality, they were variably co-opted by state ideologies and dominant castes. Any effort to reclaim them for mental health needs to critically differentiate between subversive potential and present saffronized appropriations. However, colonial modernity sidelined them in favour of biomedical, individualistic, and clinical models brought from the West.

This is not a matter of simply recouping lost traditions. It is a matter of getting at how colonialism delegitimize Indigenous ways of knowing by coding them as mystical, irrational, or anecdotal, thereby justifying the institutional hegemony of biomedicine and psychiatric reason.

The first university in India to introduce psychology was Calcutta University in 1919; a Western framework was quickly introduced. Indian psychology has been mandated to be a part of the psychology students' curriculum. However, it is talked about very slightly and does not stand a chance in front of the Western framework.

This erasure continues to impact mental health care access and shape in contemporary India, such that we need to ask what healing would look like if it were centered around our epistemologies.

## **2. The Ecosystem of Indigenous Indian Psychology**

Indigenous Indian psychology should not be defined as an adjunct or spiritualized branch of Western models of mental health. It represents a unique system of epistemology, one that synthesized ethical life (dharma), action (karma), suffering (dukkha), and liberation (moksha) into teleological understandings of psychological well-being. It focuses on the importance of community and how, with community practices, an individual can feel at peace.

These epistemic breaks were not accidental but rather strategic. By setting aside dharmic and oral knowledge, the colonial state reaffirmed a system that posited modernity as Westernization and healing as a clinical abstraction, rather than community or cosmology. Ancient Indian thought emphasized the theory of the unity of body and soul and explained how to deal with health and mental health problems, psychosomatic health problems. These concepts are part of Indian history and not borrowed from colonial rulers. Schools of philosophy such as Buddhism and Jainism focus on being mindful, compassionate, and nonviolent, whereas Samkhya, Nyaya, and Vedanta offer structures for interpreting human action and consciousness.

Nevertheless, it is important to emphasize here that a great many of these traditions—particularly Brahmanical schools such as Vedanta and Ayurveda—are founded in caste hierarchies and exclusion. Indigenous psychologies should not be conflated with Sanskritized elite traditions. What is required is not a return to tradition, but a radical rearticulation of plural indigenous epistemologies, particularly those silenced by colonial as well as casteist knowledge regimes.

This view is not lost on practitioners either, the counsellor at BU mentioned, "Like in my place, again it is sort of counselling but they believe that some power of spirituality that would help but

again it is more of helping them sit in a safe environment and talking to them with a small touch of spirituality, that is that."

The yoga system of philosophy dealt in depth with the theoretical and practical aspects that applied to mental health, and the idea that yoga is not just for the body but also the mind was introduced through Indian philosophy. Traditional psychotherapeutic practices still practiced in India are now universally well-known techniques; they include yoga therapy and transcendental meditation. Furthermore, the humoral theory by Hippocrates was preceded by Ayurvedic writings. Ayurveda also contributed to knowledge about diet, diseases, and their association with a specific physical constitution.

In the Upanishads, the interest shifted from the objective to the subjective, from the outside world to the self, whose infinite depths the universe is reflected in its entirety. The Upanishadic seers extended the tenets of spirituality to the utmost bounds of human existence. In the case of testing premises about self and transcendental knowledge, self-verification by using first-person experiential methods, like meditation, was considered the best option. This tradition of questioning and free thinking impeded Indian psychology for centuries.

This is not lost knowledge; it is dormant resistance. A reclamation of this epistemology could be the foundation of a mental health revolution based in self, society, and cosmos.

However, we also have to be careful. Not all Indigenous knowledge systems are liberatory by nature. They could have casteist, patriarchal, or hierarchical biases of their own. A decolonial thinking needs to be critical and selective to look for not return, but rearticulation

### **3. Why does the Western model not fit in collectivistic India**

#### **3A. Individualistic Therapy vs Collectivistic Cultures**

Western psychotherapeutic conceptions rely on liberal individualism based on the self-authorizing, self-realizing subject. Indian social life, by contrast, is configured through relationality, interdependence, and communal embeddedness. Healing, therefore, cannot be disembedded from social texture and reduced to a personal, professional exchange. According to Raewyn Connell

(2007), the global knowledge economy of psychology sidelines Southern knowledges in the process of universalizing a culture-specific, class-specific framework as neutral science

During an interview with a community member who is a student from Assam, he talks about the unaffordability of mental health care, "Fees and affordability are a challenge, and I understand the effort and labour that goes into managing the session, but the fees for counselling students are high, 1500 or sliding scale being 1200, which is not less." While talking about his current therapist, he mentions, "Now the therapist has a pay-what-you-can, I have a budget on what I can pay, and if I could not find someone who fits the budget, I would not seek help."

This affordability crisis isn't a defect in the system; it is its hallmark. Mental health in neoliberalism is configured to cater to the able, urban, upper-caste few. As sociologist Shraddha Chatterjee writes, the 'clinical gaze' in India tends to reproduce caste-capital formations, where care is provided to those who are capable of normative distress and who can pay for its solution.

Neoliberalism reconceptualizes care as a market exchange outsourcing mental suffering as individual lack and insourcing structural violence as 'resilience deficits'. As Esposito and Perez (2014) contend, the neoliberal mind privatizes suffering while exempting systems from accountability. In India, this takes the form of expanding life-coaching, corporate therapy apps, and expensive counselling, none of which question caste, poverty, or institutional violence.

Jay, (name has been changed for anonymity) director of Earth's Saviours, critiques the western formalized structure of therapy, which focuses more on documentation, professionalization and abstract idea of treatment instead of basic human needs.

"Despite all the rules that psychology has, what truly applies to the nature of healing and the process of giving therapy to others leads back to humanity."

He further mentioned how simply interacting, playing games, and sharing stories in a group setup positively impacts the patients.

When talking about hybrid models, the counsellor at BU says,

"If we can combine it like an 80 (Western) 20 (traditional), it could work; more and more people are moving towards Ayurveda and naturopathy."

While dominant Indian psychological thought tends to refer to works such as the Upanishads or Ayurveda in order to extend a native legacy, this history is not a simple one. These are Brahmanical, Sanskritic systems that, by definition, exclude Dalit, Bahujan, and Adivasi

populations. Authentic Indigenous Indian practices of healing are oral, somatic, and based in everyday social life, regularly dismissed as 'superstition' or simply omitted from psychiatric writings. As Spivak (1994) points out, retrieving the 'subaltern' voice involves not so much turning to tradition as recovering what tradition suppressed

Community healing marks the transition of a person from personal to social identity. People develop a feeling of responsibility, competence, and interdependence, and feel reassured that they are not alone and that their predicament is not unique.

### **3B. Education, Folk Knowledge, and Community Healing**

Folk wisdom is summarily ruled out as unscientific because it refuses codification in Eurocentric empiricism. However, such 'pluriversal knowledge' is living epistemologies rooted in ecology, ritual, and relational care that have kept communities alive for far longer than the biomedical-industrial complex. Folk wisdom manifests in proverbs, folklore, legends, poetry, rituals, and mythologies.

Dala's work reflects that the folk wisdom manifested in the traditional healing practices is, indeed, based on complex and cohesive systems of thoughts and beliefs, derived from philosophical texts and scriptures. Not only do the folk practices derive their legitimacy from the scriptures, but they have also proven to be effective vehicles to translate the essence of the scriptures into dialects that the ordinary person can follow.

Healing rituals tend to be embodied epistemologies, oral, sensorial, performative modes of care that are outside the logics of standardization. Instead of collapsing them into 'alternative therapy', they have to be regarded as insurgent practices forms of bottom-up resistance against biomedical erasure. Such images of community, metaphors, and rituals create shifts in embodiment and affect that clinical speak therapy cannot often elicit. They are somatic, social, and linguistic interventions, different, rather than inferior, forms of healing that require epistemic pluralism.

Regarding reforms and educational changes, both the counsellor and the student from Assam had similar viewpoints.

The counsellor mentions, "Somewhere in our education system has to change when you talk about mental health, somewhere from a young age, in the school, can inculcate topics or workshops or weekly talks on mental health, how do you identify symptoms, how do you not judge them..."

Furthermore, the student from Assam also believed that, "You cannot lay corporate mental health, which is how it is now. It has to be accessible like everyday medicine that you can get in a Sarkari hospital." "If you are going to roll out a scheme, you do it in education, that is where the grassroots lie. You build a generation, so there has to be proper counselling services in primary schools."

Yet folk traditions also need to be de-casteified and democratized. Too many so-called 'indigenous' healing systems have been mediated by caste hierarchies, whether in the form of temple healing, Brahmanical Ayurveda, or guru-disciple lineages. A decolonial model needs to make a difference between 'local' and 'liberatory', and place the knowledge of oppressed castes, tribes, and marginal groups at the centre, not merely elite appropriations of tradition.

#### **4. Learning from Global Community-Based Mental Health Models**

As India struggles with a dysfunctional system, some global models have proved that alternatives are feasible and already in existence. They are not blueprints; they are inspirations.

Jay from Earth Saviours talks about community and peer interaction. People share stories, sit with them, play games with them, give them love, and spend time with them, and that is when they start to have an impact." "More than counselling or assistance, their mental health improves through mere interactions with other people; they have had no home, so any resemblance to that brings a sense of safety and understanding..."

"After this, whatever counselling people do for them, talk to them, indulge them, give them love, hug them, 95 per cent of the time. The level of paranoia and schizophrenia also comes down to talking, walking, eating and speaking normally, which is a huge thing."

This report shows how therapeutic change usually occurs not by clinical processes but by steady, embodied community care, disrupting mainstream medicalized treatment.

Models from around the world based on community-integrated mental health care demonstrate that inclusivity, accessibility and localized care help bridge gaps in traditional psychiatric care.

From Brazil's chargeless CAPS model tailored to community-based mental health, integrating crisis intervention with leisure to User and survivors of psychiatry; Kenya's USP-K, a peer support group inclusive of members with lived experience specially promoting members' agency and autonomy, these initiatives highlight how mental health care can be effective, affordable, and sustainable.

Learning from these strategies, this part seeks to identify how India may model and introduce a comparable state-supported (funded) community-led, peer-enabled scheme based on its socio-economic context.

In his interview, the Ngo director rightly mentions, "Despite all the rules that psychology has, what truly applies to the nature of healing and the process of giving therapy to others leads back to humanity."

## **5. Adapting Global Lessons: Accessibility, Peer Support, Crisis Intervention Accessibility and Localized Care**

Atmitya, Gujarat: Volunteer-based outreach and peer support can help increase awareness and reduce stigma (psychoeducation can be a significant part).

Keyring, UK and Ireland: Decentralized "mental health clusters" for communities and care homes within walking distance. Bringing mental health services closer to people.

Interviews were conducted to get individuals' views on the community-based model for mental health care, and the following responses were noted.

Counsellor: Biggest problem faced by people: lack of awareness of the psychologists or counsellors around them; stereotypes against mental health care, being judged, holding them back

Community member: Group or peer sessions, community-based ones? Do you have thoughts? I will be, but I do not know how I will feel. Much sensitization will go into it; the idea is very Indian. State-supported models are okay.

NGO director: People share stories, sit with them, play games with them, give them love, and spend time with them, which is when they start to have an impact (role of community).

More than counselling or assistance, their mental health improves through mere interactions with other people; they have had no home, so any resemblance to that brings a sense of safety and understanding; otherwise, counselling to many people comes and goes, but there is no difference.

*Application to India:* If liquor stores can be located nearby, why not mental health clinics? We have abundant liquor stores, and time to bring neighborhood mental health clinics. Integrating Mohalla clinics with psychiatric services and employing qualified counsellors, psychiatrists, and social workers is also important.

*Policy Suggestion:* A mandatory provision to have

1. Mohalla clinics are being equipped with psychiatric care, and
2. Mandatory accessibility radius for mental care hubs (let us say within 10 km of reach of the other).

## **5A. Crisis Intervention and Community Support**

CAPS, Brazil: 24/7 mental health crisis centers via certified Quality Right Assessment Tool Kit, providing recreational and vocational activities (like daycare or nursing homes).

Aung Clinic, Myanmar: Provides outreach services along with follow-ups. Day clinics prevent hospitalization for individuals and provide individual counselling, group therapy, medication, vocational skills training and peer support groups.

BET Unit, Norway: Focuses on functional coping strategies to help individuals acknowledge and accept the frightening thoughts rather than avoidance and substance abuse.

USP-K, Kenya: Peer support groups with members who have lived experiences. It empowers individuals and promotes member agency and autonomy.

Atmitya, India, also acts as an example of peer support and community ownership; the key takeaway is that volunteers can identify those in distress and have an early intervention.

*Application to India:*

The idea is to set up community crisis centers in high-stress urban and rural zones, integrate community medicine mobile vans with mental health care to bring education, awareness and mental health care closer to people who do not have access or means to reach the crisis centers. Regular follow-ups, vocational training, and peer groups will be implemented to facilitate regular

interaction and avoid relapse. Besides, creating a community and being part of group activities regulates individuals.

Also vital to train counsellors in therapy first, rather than over-reliance on psychiatric drugs.

Implementing peer-led mental health networks within schools, workplaces and local community centers or areas is required to promote community-based awareness.

Mandating employer-based mental health support groups in the corporate and labor sectors can prove efficient for organizations dealing with a lack of community or workplace stress.

## **6. Regulating the Workforce and Expanding access**

Another significant issue is India's severe shortage of qualified mental health counselors and clinical psychologists, combined with regulatory compliance gaps.

Research states, "With 1.36 psychiatrists per 100,000 people, India has fewer than half the 3 per 100,000 the World Health Organization advised. Just 3372 clinical psychologists, 0.24 per 100,000 people, are registered with the Rehabilitation Council of India (RCI), the body governing services for people with disabilities, including mental health problems."

"This leaves a gap where sub-standard counselling services run by well-meaning but insufficiently trained people, as well as rogue counsellors out to make money, abound," says Sujit Sarkhel, professor at the Institute of Psychiatry, Kolkata, and editor of the Indian Journal of Psychiatry."

Policy Suggestion:

- Licensing counsellors (similarly to how RCI provides licensing to clinical psychologists)
- Introducing low-cost training programs
- Integration of mental health into ASHA and Anganwadi training to equip rural health workers to provide basic support

## **7. India-Specific Proposed Model: Mohalla Clinics, Mobile Units, and Integration with Education**

The uneven spread of mental health care is responsible for profound inequities in treatment, particularly in underserved and isolated communities. To reverse this, India must make mental health facilities an indispensable component of public health infrastructure, not a secondary

amenity. This encompasses obligatory state-funded neighborhood mental health clinics integrated into the prevalent community health organizations such as Mohalla Clinics and projecting their scope and accountability by multi-sectoral integration.

These clinics need to do more than clinical psychiatry or counselling in isolation; they need to be community care centers and places that can address not just mental health issues, but also the social, legal, educational, and structural determinants that give rise to them. To this end, an important observation was made by one of the people interviewed, the head of an NGO:

"If the sarpanch or local MLA of that clinic get involved and there is a rule that there is a committee of 5 people, DC, CJM, counsellor, CWC referred person who takes care of that particular area, like a corporation and they are in charge of these clinics, then problems can be solved."

"Because people will not just have mental health needs, they will have other problems, and a counsellor can hear just that, but if they cannot refer to the problem-seeking solution, then they will feel lost."

In order to facilitate such community-based governance and efficient delivery of services, the following policy recommendations are put forth:

#### Policy Recommendation: Neighborhood Mental Health Hubs

##### 1. Mandatory Accessibility Radius

One community mental health clinic in each 10-kilometre radius in urban and rural areas, with outreach coverage through mobile mental health vans in far-flung or ecologically inaccessible regions (e.g., through boat clinics in Assam).

##### 1. Key Services Offered

- Walk-in individual and group counselling
- Crisis intervention and emergency care (24/7)
- Peer support groups and circles of reflection
- Psychoeducation activities with cultural narratives and local metaphors in local languages
- Thought Box programs in schools: anonymous drop-boxes for kids to express emotional needs or issues
- Career and rehabilitation counselling

### *1. Integration with Key Sectors*

In order to make these hubs effective and intersectional, the following sectors have to be integrated:

- Legal sector: Involvement of the Chief Judicial Magistrate for crisis redressal, rights-based referrals, and protection
- Education sector: Collaborations with local schools, Anganwadis, and education departments for child-centered interventions
- Child and women protection: Incorporation of CWC members, social workers, and convergence with One Stop Centers
- Local governance: Monitoring by sarpanchs, ward members, or MLAs to improve accountability and local participation
- Employment and livelihood: Convergence with Skill India, NREGA, and vocational rehab schemes to facilitate occupational therapy
- Public Health: Correspondence with NRHM/NUHM, training of ASHA, ANM and health volunteers in elemental psychological first aid
- Disability and Social Welfare: Referral systems for housing, nutrition, pensions, and other support services

### *2. Governance and Monitoring Mechanism*

Every clinic should be monitored by a five-member intersectoral committee, consisting of:

- District Collector or Block Officer
- Chief Judicial Magistrate or Legal Aid Representative
- Trained Counsellor/Clinical Psychologist
- Child Welfare or Social Protection Officer
- Elected Representative (Sarpanch/MLA)

This model of integration recognizes that distress among people does not occur in isolation. An individual who is facing a mental health problem can also be facing domestic violence, financial loss, caste-based oppression, judicial injustice, or homelessness. Therefore, a counsellor in isolation cannot address the problem unless there are established referral routes, redressal mechanisms, and rehabilitation channels.

By integrating mental health into the state's broader welfare framework, and nationalizing mental health policy through localization, this model seeks to create a fair, equitable, and culturally-grounded care ecosystem.

Progress in this regard can be assessed according to the following criteria:

- Presence of an official mental health policy
- Programs or plans for mental health
- Budgetary allocations
- A dedicated mental health workforce
- Availability of essential psychotropic medications in primary care
- Increased treatment coverage
- Reduced suicide rates
- Protection of the human rights of those who have a mental illness

## **8. Funding and Feasibility**

In an already underfunded public health care system, the concern for finding funding for an additional unit is legitimate.

Potential funds can be derived from:

- Public-Private partnership, like Reliance or Tata Group, government funding with CSR support
- Integrating mental health services with Ayushman Bharat (extending to regular therapy and non-physiological disturbances) and ESI schemes

Community-based models have been working worldwide; India needs to scale up in a way that tailors to local needs. Mohalla mental health clinics can prove to be a scalable, efficient, effective and sustainable solution to the mental health crisis we currently face.

There will be potential challenges like workforce for these clinics, training ASHA and Anganwadi workers, plus community volunteers to provide basic mental health first aid. Besides, many unemployed counsellors are licensed to ensure quality counselling and move above substandard mental health care. We must integrate these services into the public healthcare system, schools and workplaces to ensure people use these clinics.

## **Limitations and scope for future research**

While this paper provides a decolonial reimagination of India's mental health care system critically, it is not without its limits. It does not undertake an ethnographic investigation of particular Adivasi, Dalit, or folk practices in depth, even though it does grapple with Indigenous models of psychology and community care. Subsequent studies could place these knowledge systems more centrally through field experiences and oral histories, as opposed to secondary representation.

Second, the paper relies almost exclusively on a limited number of interviews, which, though insightful, provide no statistically generalizable sample. The views emphasized are representative rather than exhaustive and should be interpreted under the limited confines of qualitative work.

Third, the pragmatically oriented policy recommendations are not supported by a complete cost-benefit analysis or bureau-feasibility study. Additional research must involve joint collaboration with policymakers, economists, and public health professionals to experiment with the scalability of models proposed, such as mohalla clinics and mobile crisis units.

Lastly, the effort to reconcile spiritual and cultural practices with Western-style formal mental health care could also risk inadvertently endorsing casteist or patriarchal schemas unless critically scrutinized. It is essential to regularly monitor which traditions are being reclaimed, by whom, and at what cost.

In spite of these constraints, this essay would like to provoke a dialogue between disciplines, between past and present, between state and citizen that brings us closer to a mental health system grounded in justice, care, and collective healing.

## **Conclusion**

The idea may seem too ambitious or idealistic, but if worked through in phases, we can achieve a model to help provide accessible and affordable mental health care. Community-based peer-supported psychoeducation combined with community participation and community-based care centers can be a significant step towards normalizing mental health care and destigmatizing mental health disorders.

Adequate funding through the state and central government, integrating mental health services into public health care, and introducing licensing regulations for counsellors are necessities to ensure quality counselling services.

This phased approach may seem ambitious, but revolutions rarely begin fully formulated. They emerge with belief, hope, structure, and the will to prioritize people over protocol.

The sense of urgency of this change cannot be underscored. Mental health needs to be regarded not as a luxury or only an individual concern, but a state responsibility and a community entitlement. Without structural change, all the resilience of individuals or cultural recovery can fall short.

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