MALEMBE, MALEMBE?

TECHNOLOGY FOR MENTAL HEALTH IN DETENTION

H U D

WORKING PAPER

JONATHAN LUKE AUSTIN

Fonds national suisse

—HEAD Genève

GENEVA GRADUATE INSTITUTE

EPFL

UNIVERSITY OF COPENHAGEN

WWW.HUMANITARIAN.DESIGN

H U D

KØBENHAVNS UNIVERSITET

Malembe, Malembe: Technology for Mental Health in Detention
A *The Future of Humanitarian Design* (HUD) Working Paper

Copenhagen | Geneva | 2025

Author Biography:

Jonathan Luke Austin is Associate Professor of International Relations at the University of Copenhagen. He is also Head of Studies for the Security Risk management program in Copenhagen, Director of the Hub for the Future of Advanced Security and Technology Research (FASTER), and a Principal Investigator for the Future of Humanitarian Design (HUD) research program.

Contact: jla@ifs.ku.dk.

Malembe, Malembe?
TECHNOLOGY FOR MENTAL HEALTH IN DETENTION

JONATHAN LUKE AUSTIN

This page is intentionally left blank.

1.
EXECUTIVE SUMMARY

> While political and military cataclysms are dreadful and challenge the mind through the monstrosity of their violence (that of a concentration camp or of an atomic bomb), the shattering of psychic identity, whose intensity is no less violent, remains hard to perceive.
>
> - Julia Kristeva, *Black Sun*

Mental health in detention is a neglected aspect of global health and humanitarian policy. At least one in seven incarcerated individuals suffer from severe mental illness, and more than half have a history of mental health problems. These rates are significantly higher than those in the general population. More, in low- and middle-income countries (LMICs), between 76% and 85% of people with severe mental disorders receive no treatment. In this, detainees are doubly stigmatized by both their imprisonment and their illness.

The design of detention environments intensifies this crisis. Incarceration not only exacerbates pre-existing conditions but also generates new psychosocial harms that extend beyond prison walls. A 'carceral continuum' emerges, where poverty, institutional weakness, and social exclusion lead to incarceration; imprisonment deepens mental distress; upon release, individuals often re-offend, perpetuating cycles of violence or insecurity. This is a pressing global public health concern with major humanitarian implications.

Yet, despite the scale of the crisis, mental health support systems remain almost entirely absent from detention settings worldwide. Against a backdrop of declining psychiatric infrastructure and limited professional capacity, the World Health Organization's so-called "mental health gap" remains acute. In response, policymakers and practitioners are increasingly turning to technological interventions—digital screening tools, AI-driven diagnostics, and remote treatment platforms—as potential solutions.

1.1 CONTESTED TECHNOLOGICAL TURNS

While technological innovations for improving mental health and psychosocial support appear promising at first glance, their deployment in the mental health space is highly contested. A summary of only the most obvious risks involved in deploying technology in this space include:

- **Embracing techno-optimistic hype** around emerging technologies, especially AI, without evidence of scalable effectiveness or context sensitivity;
- **Technocolonialism**, where tools developed in high-income contexts are exported without adaptation to local realities, sometimes strategically extracting data from vulnerable societies;
- **Ethical and privacy concerns**, which are particularly acute in detention settings, given sensitive health data intersects with security and punishment;
- **The technical standardization of human experience**, which risks reducing complex psychosocial conditions to simplistic algorithmic categories.

Despite these concerns, deploying advanced technologies for mental health care in detention is increasingly seen as inevitable due to:

- Severe shortages of infrastructure, funding, and personnel to treat mental illness globally;
- Limited training capacity for primary care workers in and beyond detention settings;
- The complex, comorbid, and socially embedded nature of mental illness, which technological innovations have the potential to provide solutions to.

Following all this, the contemporary challenge we face is not simply whether to adopt technology, but how to do so responsibly, contextually, and in ways that produce lasting rather than superficial impact.

1.2 AMIDST: ADAPTIVE MENTAL ILLNESS IN DETENTION SCREENING AND TRIAGE

Based on extensive research on detention environments in LMIC's, HUD's working hypothesis is that the primary bottleneck in detention mental health lies in the middle spectrum of care: the lack of systematic, population-level screening and triage, at the population level. Without such screening tools, both primary care interventions and higher-level treatments struggle to function, given an ignorance of the scale, scope, and precise nature of mental health and psychosocial struggles in detention environments across the world.

HUD is therefore exploring the possibility of developing a low-intensity digital Clinical Decision Support System (CDSS) with the following capacities:

1. **Screening and triage**: Rapidly and transdiagnostically screening-for and triaging mental health and psychosocial issues at entry to detention settings, during detention, and at release;
2. **Referral management**: Linking at-risk detainees to available resources and services both within and beyond prison, supporting the development of sustainable referral pathways;
3. **Low-intensity treatment support**: Enabling non-specialist staff to provide basic psychosocial support, following task-sharing and stepped-care models;
4. **Training and capacity building**: Provide health and social workers with accessible tools for MHPSS delivery, increasing local expertise in humanitarian settings;
5. **Diversion from justice systems**: Support pathways that redirect individuals with mental illness away from incarceration and toward health services.

Preliminarily, we name such a tool AMIDST; **A**dapative **M**ental **I**llness in **D**etention **S**creening and **Triage**. The goal of AMIDST would not only be to improve health outcomes but also to challenge entrenched biomedical and carceral paradigms, many of which are rooted in colonial legacies of control. In particular, by co-designing tools *with* frontline healthcare workers, communities, and detainees themselves, we envisage LMICs not as sites of experimentation, but as drivers of globally relevant innovation in mental health care.

1.3 MALEMBE, MALEMBE: SLOW AND CARE-FULL INNOVATION

Addressing mental health in detention is an ethical and practical imperative. The current absence of screening, triage, and referral systems perpetuates suffering, stigma, and cycles of violence that destabilize entire societies, even geopolitics. Yet, while digital technologies offer promising avenues to address these gaps, they carry significant risks if deployed hastily, uncritically, or without attention to power structures.

AMIDST, and HUD's wider work in this area, area is thus grounded in an ethos encapsulated in the Lingala phrase *malembe malembe*—"slowly, slowly," "calmly, calmly." Rather than rushing toward sweeping technological fixes, this approach emphasizes cautious, participatory, and context-sensitive innovation. It also acknowledges the epistemic, social, and political injustice that pervade humanitarian psychiatry globally, cautioning us to always be aware of the risk of reproducing such violence when intervening in this space.

By focusing on detainees as a defined population, embedding interventions in local contexts, and returning decision-making power to health and social workers in humanitarian contexts, this initiative therefore has the potential to catalyze a paradigm shift in how humanitarian actors, policymakers, and governments approach mental health in detention—globally, not just in LMICs. Ultimately, the question of mental health and psychosocial care is not simply a technical challenge, but a political and ethical one. To succeed in creating truly transformative change, humanitarian policy must treat detainees not as forgotten populations at the margins of society, but as central to the struggle for public health, justice, and human dignity.

2.
INTRODUCTION

At least one in seven people who are incarcerated have a severe mental illness (Emilian *et al*, 106). And at least 50% have a history of mental illness more broadly. These rates are **double those of the general population.** More, evidence suggests that this figure is higher in low and middle-income countries (LMICs), where infrastructure for the diagnosis and treatment of mental illness is very limited even outside prisons. Indeed – generally – between 76% and 85% of people with severe mental disorders receive no treatment in LMICs (WHO 2019) . In prisons, this number is likely much higher. **As such, prisoners with mental illness are a doubly hidden population:** stigmatized because of both their detention and their illness.

A prison is a microcosm of society; mental health problems therein are thus not contained within its walls. On the contrary, a psycho-social carceral continuum exists. Poverty causes mental illness; institutional weakness leads those suffering from mental illness to be directed to prison; upon leaving prison, re-offending is common; criminal activity in urban neighbourhoods increases; risk of engagement in armed violence increases; other forms of violence (intimate partner, child neglect), etc. increases, and so forth. The spiral of this carceral continuum is thus stark and **a key global public health concern yet unaddressed.**

But mental health screening, triage, and referral systems are absent in prisons or detention settings in *both* low-income, crisis-affected, or humanitarian settings *and* many high-income contexts. Indeed, levels of psychiatric bed provision in many LMICs have stagnated or declined since 1990 (Fig 2), while the prevalence of mental health and other issues has not declined *globally* for over 25 years (Nadkarni et al 2024, 3353). One response to the seeming intractability of this 'mental health gap,' as the World Health Organization calls it, has been a rapid – yet contested – **turn towards possible technological solutions**.

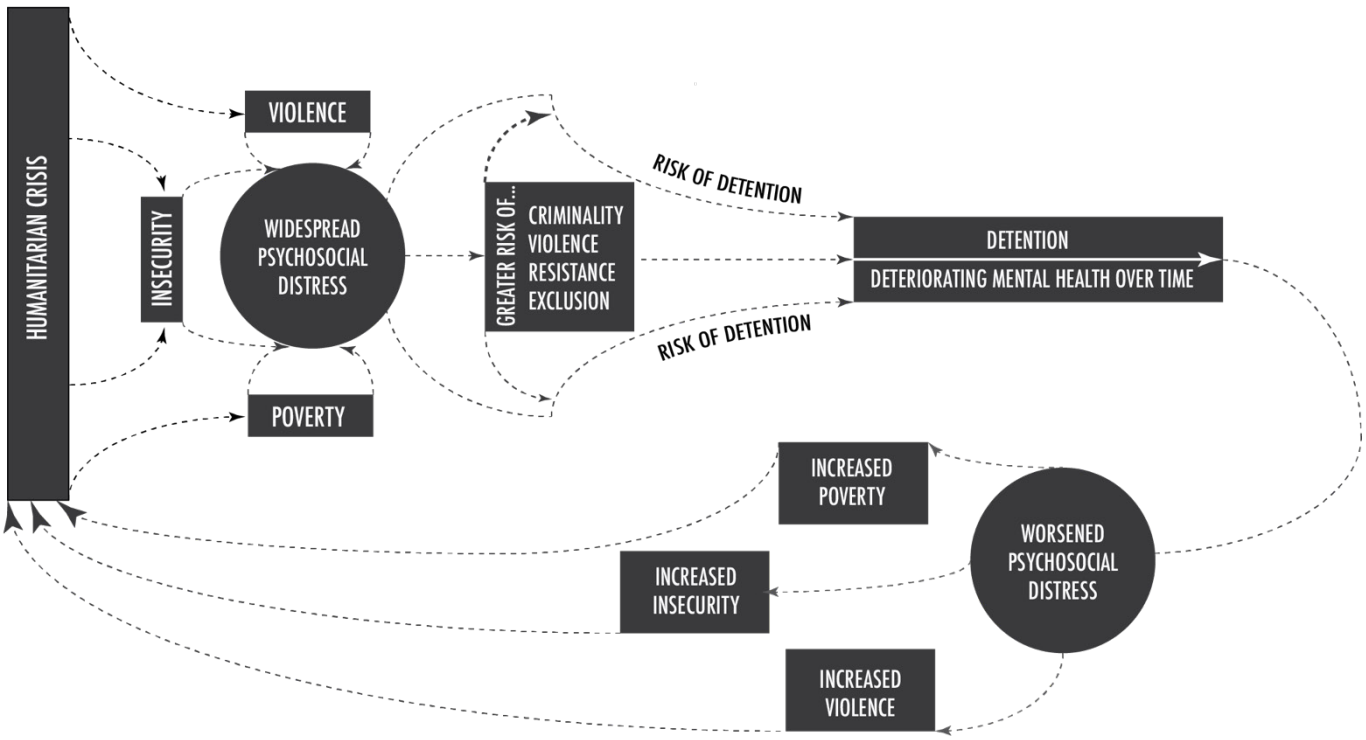


Figure 1: *Model of how detention in humanitarian crisis creates feedback loops of mental distress, worsening humanitarian crisis over time.*

3.
CONTESTED TECHNOLOGICAL TURNS

Mental health care within high-, middle-, and low-income countries is undergoing a rapid technology-driven transition. These shifts are suffused with the general risks facing the deployment of technology to solve social problems: hype over emerging technologies, data protection risks, technocolonialism, the standardization of human life into algorithmic patterns, rampant commercialization, and more. These issues are especially controversial vis-à-vis mental health, where the 'immateriality' of the phenomenon – the inability to objectively fix what mental health or mental illness actually *is*, given the complexity of its social, political, environmental, *and* biological drivers are – make the risks of technological solutionism very acute.

Despite these concerns, the **deployment of technology in this area has become more-or-less inevitable** for several key reasons:

1. **Medical resources** – infrastructural, financial, logistical, and human (see below) etc. – to diagnose and treat mental health conditions in detention are **severely lacking globally** and evidence suggests that digital solutions are effective in filling this gap;
2. **Staff training** (human resources) to diagnose and treat mental health conditions is **especially limited in humanitarian and detention settings in** *both* LMICs and HICs, but again evidence suggests technology can help;
3. The **complexity of mental health conditions**, which require trans-diagnostic approaches that consider the prevalence of co-morbidities and socio-ecological (as opposed to physical) aetiologies, etc. is a problem that is **possibly especially amenable to technological intervention.**

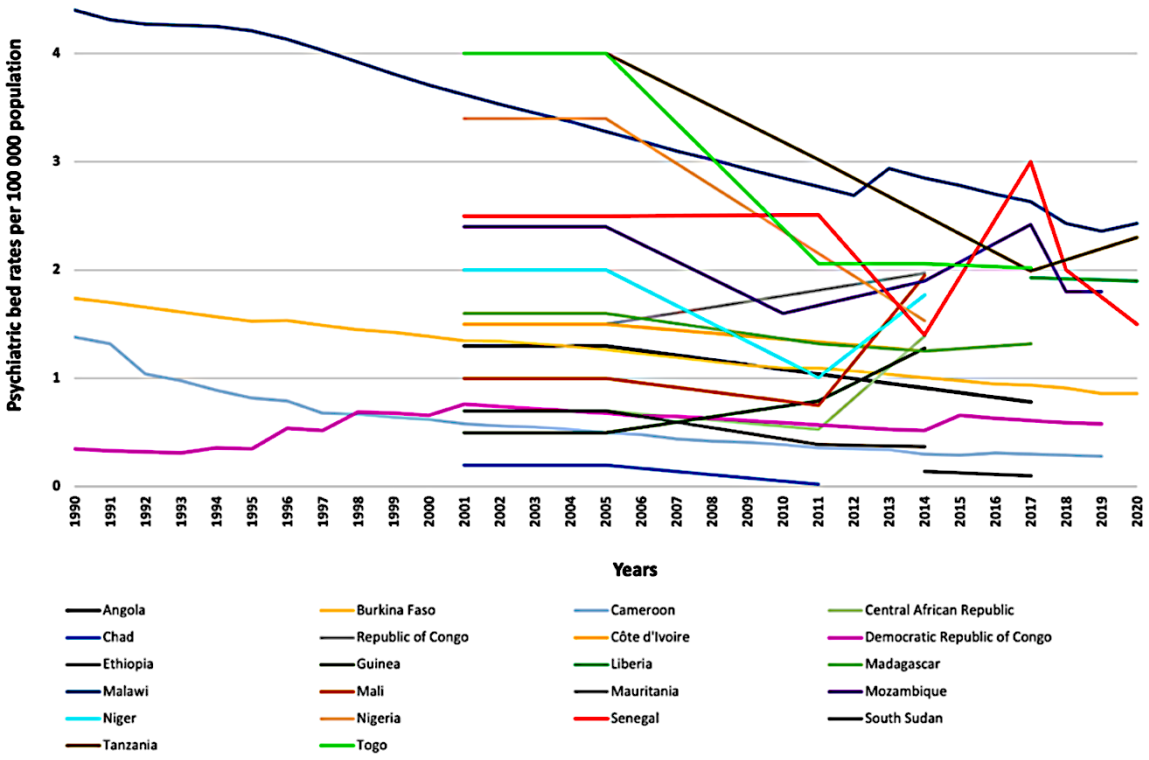


Figure 2: *Number of psychiatric beds per 100'00 population in selected LMICs, trends from 1990-2020.*

Given all this, emerging technologies are seen as having the potential to work as **cost-effective, scalable, and context-sensitive** tools to improve mental health conditions in prisons and detention *across the world.* Consider the following remark from a Nigerian forensic psychiatrist:

> Akin to other international domains, there is an urgent need to expand the uniformity and coverage of psychiatric screening programmes in correctional environments in Africa, AI could offer viable solutions for this, though at the time of writing, AI-driven screening remains untested within African prison settings (Ogunwale 2024, 2).

But the key words here are "*could offer*… solutions." Technology has been deployed in the realm of mental health in and beyond LMICs for decades. But it has been **harder to deploy these technologies in ways that are effective**: producing tangible change in different scalable contexts across the world. The turn towards 'AI,' for instance, is simply the latest over-hyped solution to the problems identified above. There are a series of serious **demand- and supply-side barriers to technology in this area**, barriers which must first be fully taken in to account to produce *positive* rather than simply ad-hoc palliative change in this area.

Figure 3: *Types of mental health intervention and their level of technological dependency.*

4.
HUD'S ETHOS: MALEMBE, MALEMBE

How can we work-with technology, yet mitigate its evident-risks, to improve mental health care in prison and detention settings in humanitarian contexts? At one level, it is clear that we need to develop a multi-sectoral, socio-ecologically embedded, participatory, and context-sensitive approach to developing technological innovations in this area. But how to get there? What do these buzz words really *mean* here?

Given the range of **social and technical** problems to be addressed, HUD might begin with the Lingala mantra in the Democratic Republic of the Congo that one should deal with things *malembe malembe – slowly, slowly – calmly, calmly.* Against the dream of all-encompassing technical solutions, we must first take a step back, returning to fundamental user-needs before making technological choices. While AI may play a role, it is not useful to start thinking about AI *first.* Instead, Figure 3 visualizes the range of options in this area, and the degree of complexity, technological sophistication, and other elements they require to be realised.

Despite this wide range of possible technological interventions, the **main blockage to mental health care in detention sits in the middle of this spectrum.** Without having a 'second order' capacity to screen defined populations for mental health and psychosocial issues – to diagnose *within a group* – it is far more difficult to mobilize direct primary care interventions *of any kind* and/or to advance tertiary enablers of medical treatment that require such granular data on the scope, extent, and precise nature of a problem.

A focus on a **low-intensity intervention** at the level of clinical decision support is thus a *slow* yet critical and pragmatic starting point: something that may increase the core capacity to screen, diagnose, and triage MHPS issues within detention settings. Indeed, working to develop a clinical decision support system in this area has the potential to scale to improving the quality of care, the control of attrition rates, rehabilitation services, etc., but also has virtues even without these other benefits necessarily materializing.

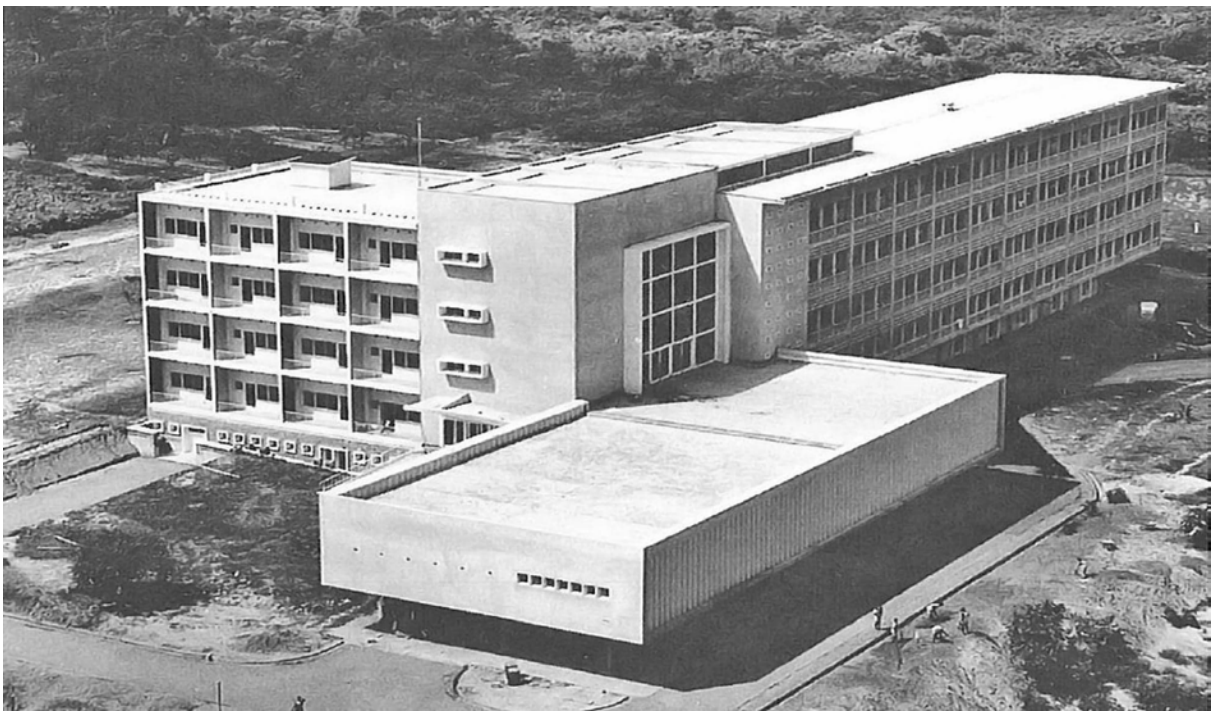
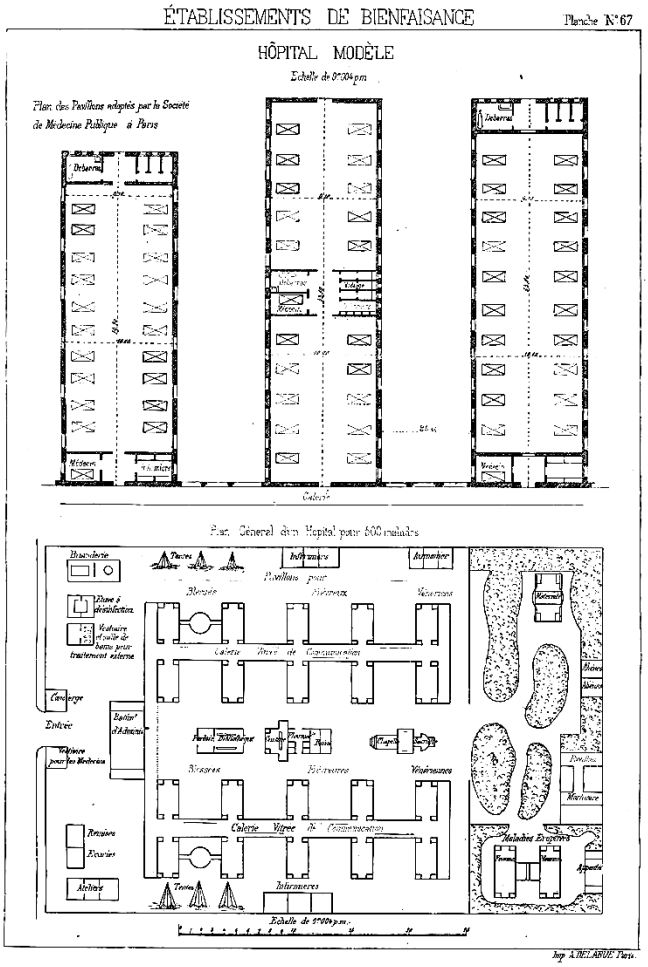


Figure 4: *Makala Sanatorium, Kinshasa, pictured during the Belgian colonial era. The hospital still serves detainees at Kinshasa's central prison, also constructed by Belgium.*



Figures 5 & 6:

Left: architectural designs for a hospital to be constructed in the city of Mbandaka by Belgian colonialists. Below: satellite image of Makala central prison in Kinshasa. The architectural form of each structure echoes the other in its 'pavilion' logic – associated with racial segregation and control.

More, working at this low-intensity level is important socially and politically. Efforts to deploy complex technologies in this area are criticized not only because of the lack of contextual fit they demonstrate in *both* HICs and LMICs but because they naturalize a particular understanding of MHPSS. Indeed, the very idea of a 'mental health gap' as it is currently understood has been criticized for emerging from a biomedical understanding of mental health that might miss not only the real 'scale' of this gap but also where it should be identified more precisely and, in particular, its socio-political content (Littoz-Monnet 2022).

Related to this, working at this slow, careful, level has other potentially radical benefits. It is not possible to disassociate both contemporary biomedical paradigms *and* modern forms of incarceration from their colonial roots. Kinshasa's central prison, Makala, was constructed by Belgian colonialists in 1957. Not far away, the Belgians also constructed a new sanatorium. Both facilities are still in-use, little changed, and their architectural designs are mirrors: both follow an architectural structure whose design explicitly sought to enforce forms of racial segregation, under the guise of good medical-carceral practice (Nys-Ketels 2023).

The roots of biomedical understandings of medical health are – therefore – situated in a desire to *limit* the decision-making powers of the disenfranchised, as has been widely discussed in social theory. There is thus a further good reason to return to considering how technological change in this area might be leveraged to *return* different forms of decision-making power to these actors. Moreover, such a step – if integrated into technology design processes – would allow us to see sites like the Congo, Colombia, or elsewhere as new resources for *global change*. Typically, these contexts remain sites of experimentation – in which corporations abuse the lack of power of communities to expand the scope of biomedical paradigms. Yet, the **failure of these approaches even within HICs**, where both prisons and mental health care are in equal crisis, suggests that intervening in this area may **allow for a paradigm-shift driven by LMICs themselves.**

Figure 7:

A photograph from inside Mbandaka's central hospital, during the colonial era. The corridor structure was intended to enforce racial segregation and control over patients, echoing precisely the logic of contemporary prisons globally.

5.
HUD'S PRELIMINARY GOALS

Develop a digital Clinical Decision Support Systems (CDSS) for prison and detention mental health that focuses on:

A. **Screening (entry/detention/exit)** for mental health and psychosocial health conditions with a focus on **triaging** at the **defined population** level of detainees during primary care (possible 'high-risk' detainee focus – level of acuity);

B. **Managing a referral pathway** for identified high-risk detainees during entry, detention, and exit, that **works with existing resources, knowledge, and capacity in the identified contexts**;

C. **Supports low-intensity treatment** following screening, supported by a task-sharing model that exceeds biomedical paradigms wherever possible;

D. **Supports primary health care worker training** in mental health and psychosocial support, adapted to local contexts;

E. **Supports the 'diversion' of those suffering from mental health issues** away criminal justice system to available mental health services.

To achieve this, it seems critical to develop a CDSS that is:

1. **Primarily health-and-social-worker facing:**
Given the importance of mitigating the ethical risks of beneficiary-facing platforms in/beyond LMICs (treatment limitations; referral limitations, etc.);

2. **Linked to community services** ('social-worker' facing):
This can facilitate referral processes – important both given the prevalence of external actors (civil society) providing treatment in prison itself and for post-detention rehabilitation.

3. **Adaptable to ecological contexts:**
To facilitate change management, and acceptability of treatment, the intervention must move beyond biomedical and other paradigms, allowing for the adaptable e.g. i) translation of formal psychiatric diagnoses into local contexts, ii) the diagnosis of locally-specific MHPSS issues, iii) the collaboration with a wider range of medical/health professionals (e.g. indigenous medicine – not stealing jobs), (iv) considers available services, infrastructures, and resources (i.e. availability of drugs).

4. **Secure and 'non-controversial':**
The focus on detention and prison settings requires particular security protocols for data confidentiality and to assure the confidence of the relevant authorities. This will require placing limits on the design of the technology concern – e.g. an offline tool, consideration of hosting, etc., and potentially limit the integration of certain technologies – e.g. LLMs.

5. **Is (eventually) 'owned' by authorities:**
For scaling-up and sustainability, the above factors will ideally align with the interests of concerned authorities in different sites.

6.
KEY ELEMENTS TO CONSIDER

1. **Transdiagnostic Screening**

   High rates of comorbidity in mental health conditions require a screening tool that goes beyond disorder-specific screening and intervention. This is both medically necessary and would further alleviate resource constraints of different kinds in LMIC settings.

2. **Collaborative Task-Sharing**

   Given a lack of resources, task-sharing models based on integrated care concepts are important to this intervention. Such models suggest that healthcare staff with limited or non-specialist training can delivery key elements of psychosocial care for core mental health conditions in the right circumstances.

3. **(Collaborative) Stepped Care**

   To account for resource limits, stepped care approaches are important – they seek to monitor and delivery mental health care in the **most effective but least resource intensive** way – avoiding 'stepping up' to more costly services unless specifically required due to patient need.

4. **LMICs as Leading the Way**

   While the limits facing LMICs are acute in this area, it is important to note that the problem of mental health in (and beyond) detention is global – and the issues acute even in high-income countries. For many there is thus, a **need to transform our assumptions relating mental health across the world**, as well as the role of medical professionals therein. In this regard, an intervention in this area has potential scope **beyond LMIC/HIC binaries**, especially given the lack of a strong institutionalized form of mental health policy may open new imaginaries of global relevance. This might include the integration of traditional knowledge into MHPSS, a greater consider of the epigenetic effects of colonial histories, and so forth.

5. **Adaptation to Target Population to Manage Local/Global Scalability**
   Current technological interventions in this area are divided between developing highly scalable yet low-context sensitive interventions (e.g. MHGap) or highly-context sensitive yet limited-scale interventions at the country level. While this binary reflects most technology dilemmas in LMICs, specific to mental health is the further issue of the non-universal nature of the particular pathology even *within* nations, states, cultures, etc. In this, **both 'global' and 'local' interventions at present are too general in focusing on entire populations** (cross-national or national). A focus on prisoners as a 'defined population' is thus useful as a targeted intervention that is both universal and specific – potentially allowing for more adaptability: but it requires **special attention to the co-design of the intervention to meet this defined population.**

6. **A need for non-binary algorithms**

   Whether transdiagnostic or not, the nature of mental health and psychosocial support requires an intervention that can exceed binary algorithmic judgements of pathology. **In the tradition of preventive medicine**, mental health conditions are environmental, social, and political – existing on a spectrum. In this, any screening tool must be able to offer explanatory insights into the origins of pathology that are more complex than typical.

7.
DISAGGREGATED SOCIO-POLITICAL PROBLEM SPACE

1. **The punitive nature of detention and social hostility**

   Detainees of all kinds remain stigmatized as *deserving* of punishment, including a lack of appropriate medical care of all kinds. A form of **discursive transformation** on the reasons for detention and the impact of mental health issues on wider society is critical.

2. **Stigma related to mental health**

   Suffering from mental health issues remains a stigmatized reality globally. Indeed, there is a nexus between this form of stigma and that of detention: prisons often serve as *de facto* mental health holding facilities with people suffering from a mental health crisis often referred first to the police, and sometimes thereafter prison.

3. **Mental Health (Care) is 'immaterial' – abstract.**

   Despite mental health issues being acknowledged as a key public health burden globally, including in LMICs, **diagnosis and treatment is costly, time-consuming, & complex** given its immateriality – the fact that it cannot be diagnosed 'objectively' but exists due to a mix of physical, biological, environmental, social, and political factors.

4. **Mental Health is not a 'universal' social concept.**

   While the WHO, commercial actors, and others have sought to standardized mental health discourse through trans-cultural screening systems, treatment options, etc., this approach has been the subject of heavy criticism given what counts as a mental health issue is highly contextually specific and biomedical approaches typically neglect this complexity. Indeed, mental health issues hold only a kind of **contingent universality**, in which universalities of distress may exist (e.g. those that the PHQ-9 scale captures), they are expressed through different idioms and are contingent on a wide-set of socio-political factors that make trans-cultural screening and diagnosis especially complex.

5. **Staff training is limited in humanitarian and detention** settings in LMICs

   There are few *general* medical staff in prisons and other detention facilities in LMIC's, and those that exist show **variable skills**, are forced to undergo **task-shifting**, and have difficulty following complex guidelines given these conditions: high-level guidelines (especially for e.g. abstract mental health protocols) are not necessarily concrete for primary care health workers in detention.

6. **Time is limited**

   Even where appropriate training and infrastructure is present, health workers are under immense time pressures, any CDSS system must thus be time-efficient in screening and diagnosis (transdiagnostic).

7. **National Regulations**
   CDSS systems at a national level should be adaptable and configurable to national medical protocols and guidelines. But these vary considerably. There is therefore a further tension in developing 'global' CDSS systems, which requires consideration – stopgap or emergency systems can be created, but ideally they should be adaptable to national contexts.

8. **Technological Complexity and Commercialization**
    a. Transdiagnostic tools for mental health screening designed to be more efficient and over-arching exist but they are largely developed by commercial organizations and designed to be integrated into already highly sophisticated and resource-intensive health systems (typically in, e.g. the USA);
    b. This is also true for, for example, computerized adaptive testing tools that could increase the efficiency of screening – they are guarded by commercial actors and their efficacy is uncertain outside highly complex health systems.
    c. In this regard, the **commercialized nature of the health sector is itself a problem.**

Other Issues:

- Geographical differences in resources (rural, urban, etc.);
- Services may be **centralized** but **not integrated** (e.g. across prison systems);
- Inter-organizational collaboration (prison, judiciary, police) may be weak;
- Lack of political prioritization of mental health services.
- Novelty effects often introduce initial interest in technological innovations, but these fade over time (see *existing initiatives*).

8.
DISAGGREGATED TECHNOLOGICAL PROBLEM SPACE

1. **Structured/Open Diagnosis and Double Algorithmic Limits**

   The problem of trans-cultural diagnosis (see above) is doubled by the way specifically **digital** technologies are typically deployed in the healthcare and other sectors – their technical nature means that they typically work **best with structured data inputs** (especially e-CDSS, e.g. the use of PHQ-9 scales) that work across contexts but are blind to nuance. This is particularly a problem for MHPSS given its immateriality (see above).

   Clinical algorithms further this problem. Modern medical treatment follows an IF-THEN logic, whether computerized or not. This limits our understanding of MHPSS in core ways, and especially when **algorithm-driven clinical diagnoses (which need not be digital or computerized) are combined with digital tools**. A key technical challenge here is thus creating an 'open' digital tool that goes beyond an IF/THEN logic.

2. **Lack of Targeting**

   Current technological interventions in this area are divided between developing highly scalable yet low-context sensitive interventions (e.g. MHGap) or highly-context sensitive yet limited-scale interventions at the country level. While this binary reflects most technology dilemmas in LMICs, specific to mental health is the further issue of **the non-universal nature of the particular pathology even** *within* nations, states, cultures, etc. In this, both **'universal' and 'contextual' interventions at present are too general in focusing on entire populations** (global or national).

   A focus on prisons as a 'defined population' is thus useful as a targeted intervention that is both universal and specific – potentially allowing for more adaptability. But this poses additional technical problems:

3. **High vs. Low Technological Implementations**

   For many, the number of obstacles to MHPSS screening and diagnosis, in LMICs and HICs alike, requires a turn to high technology – nowadays LLMs, neural networks, deep learning models, etc. being the most obvious candidates. At the same time, the use of such technologies not only poses **serious ethical and social risks** but also may be **inappropriate to relevant contexts.** Serious consideration thus needs to be placed on the level of technological complexity that is required in the development of a CDSS and, if a more complex solution is chosen that mitigation is in place. For example, an LLM model would need to be *both* human readable *and* its model be 'explainable' more abstractly – e.g. how it reaches particular conclusions needs to be transparent.

4. **Time vs. Accuracy Trade-Offs**

   Screening for mental health conditions involves a trade of between accuracy or time, at a technical level. Standardized 'quick' screening tools (PHQ-9) are efficient to administer but rely on very limited data (lack of interest, feeling down, sleep problems, lack of energy, appetite, self-critique, lack of concentration, sluggishness, suicidal ideation) that capture only a small slice of the complexity of mental health – diagnostic accuracy is thus limited. More complex tools that are more accurate, however, take orders of magnitude more time to administer, time that is in short supply. **Computerized Adaptive Testing** provides a potential solution here, but is plagued by the various other challenges discussed above.

5. **Integration/Stand-Alone**

   General large-scape hybrid e/non-eCDSS systems have been deployed globally, but typically only where integrated into much larger human and physical infrastructures in high-income medical settings. These technologies are usually developed by commercial actors or governments. The challenge for a eCDSS system of the kind proposed here is to **create a stand-alone system** that works without such integration, but which retains as much functionality as possible. This requires consideration of the comparative **lack of financial resources and quality infrastructure** also at a technological leve.

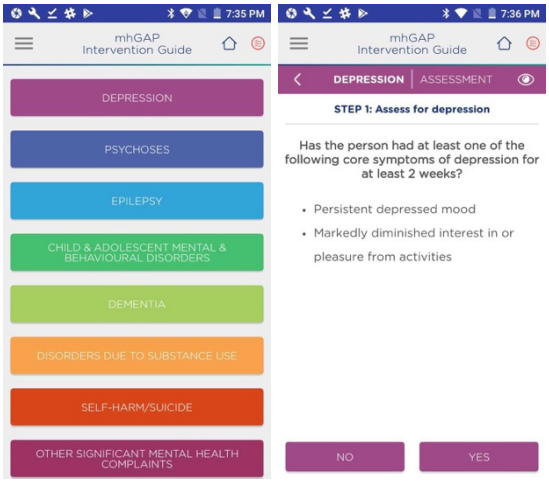
6. **Security and Confidentiality**

   Given the sensitivity of mental health diagnosis, especially but not only in detention settings, as well as medical records more generally, technological interventions pose particular risks vis-à-vis data and patient confidentiality. This also poses problems regarding the continuity of care in this sector. Such issues must be considered from the start.

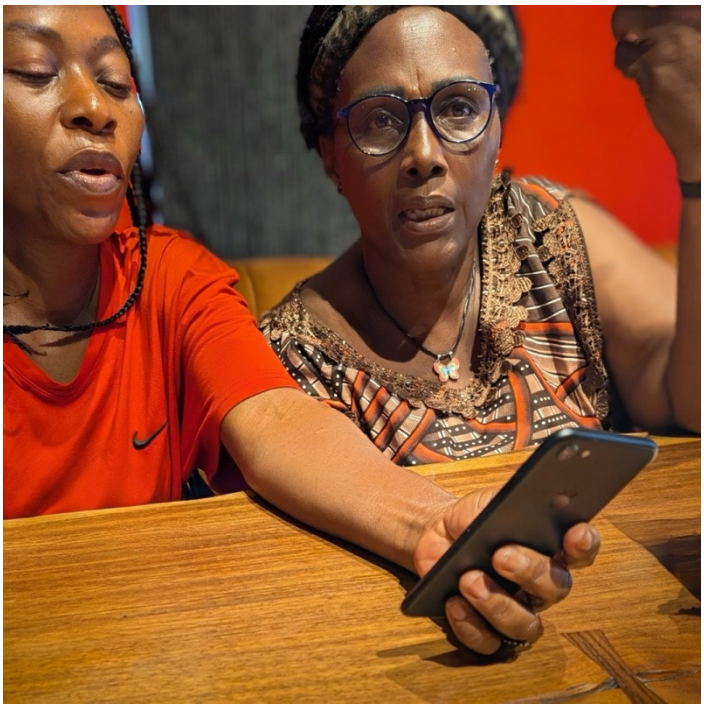
9.
EXISTING INITIATIVES AND THEIR PROBLEMS: A FIELD STUDY

The idea of developing electronic CDSS systems for global health, including in humanitarian settings, is not novel. Numerous initiatives have previously existed in this area. This includes the EU-funded MEGA project, a UN (DHMOSH/DOS) application for UN peacekeepers, various commercial initiatives, and – most notably – an electronic version of the WHO's mhGAP-IG program. Other initiatives in this area are also under development. Nonetheless, past initiatives in this area have generally failed to scale, fallen into disuse after pilot phases, or otherwise failed to materialize their proposed benefits. While certain reasons are pragmatic (a lack of funding), others involve a failure to take into account the technological, social, and political problem spaces disaggregated earlier in this working paper. Moreover, there are to my knowledge, no interventions in this area currently targeted at the defined population of incarcerated individuals (with the exception of initiatives in the self-help and remote psychiatry field, largely in North America).

To see the difficulties relating to earlier initiatives, in concrete terms, we now describe a series of focus group sessions that took place with health care workers and civil society members in the Democratic Republic of the Congo (DRC). Those focus groups introduced participants to the WHO's e-mhGAP application, and asked for their feedback on it, with the aim of gathering data on their perceived user experience, how well the app fits (or not) with LMIC contexts, and detention contexts specifically, as well as co-designing alternative options. Participants in these focus groups ran a 'scenario' on the use of the e-mhGAP-IG to screen detainees as they arrived in a prison in the DRC, to test its perceived efficacy. A full report on these activities is available on request. Nonetheless, the following summarizes the findings.



Above: Screenshots from the e-mhGAP-IG app.



Right: Participants in one of the focus group sessions held in Kinshasa, DRC examine the mh-GAP-IG app.

9.1 GENERAL OBSERVATIONS

Trained medical professionals among the participants quickly moved back to their instinctive understanding of potential mental health issues while using the e-mhGAP-IG. This included, for example, quickly glossing over the details in the prompts described given they 'already knew' what to look for. That is to say; the application sometimes became largely 'immaterial' to their work, with a fall-back on existing knowledge occurring most frequently.

This appears to reflect that:

- Despite none of the participants being trained in the (paper-based) mhGAP-IG, prior training relating to mental health and psychosocial support more broadly overlapped with data in the e-mhGAP. This is unsurprising, but it poses several issues regarding what the precise purpose of the *digital* version of the mhGAP-IG is.

- The e-mhGAP is a digitized version of the **intervention guide**, which contains a series of vertical clinical decision support algorithms that work to provide pathways for diagnosis and support. This intervention guide is designed to support **training of non-specialized staff in the medical sector**. In the end, these staff will be conducting diagnosis, with the support of the implementation guide.
- In consequence, the **electronic version is not strictly speaking conducting any diagnostic tasks in and of itself.** The tool continues to rely on **human resources substantially**. It is not an **automated diagnostic tool.** This leads to the following issues:
- **Training and follow-up of a large cadre of primary health care staff is essential, but the app itself is inessential, for the following reasons:**
    - It does not diagnose automatically, simply provides suggestions;
    - It does not disaggregate diagnostics along a spectrum of acuity;
    - It does not store diagnostic records, allowing for either their addition to medical records, or a database of granular data for analytics.

- The app itself is useful for training and decision support but does not **necessarily reduce clinical burdens**. It remains a relatively **high-intensity intervention.** As any clinical algorithm, it seeks to optimize and standardize the treatment of patients and the management of their referral pathways, but this goal of 'optimization' is not necessarily achieved through the app itself, but rather through increasing the skillset of low-level medical practitioners.

- **Technology and Human Contact**

  During the exercises, those 'role-playing' others were important, as they revealed tensions in the likely real-world use of the application. Specifically:

    - Those who 'role-played well' (e.g. put themselves into the position of a detainee arriving at prison) would sometimes not provide explicit yes/no answers (as the app asks for) but instead pause, provide other stories (that might seem at first glance irrelevant), and so forth;
    - These role-playing moves reflected real-world conditions, and **forced practitioners to deviate from the app's protocol and structure substantially**;
    - Reflecting on this (see below), the importance of maintaining human contact through an e-CDSS such as this is critical, depending on the objective.

- **Limits to the strategic universality of mh-GAP-IG**

  It has been noted that the construction of the mh-GAP-IG as a *global* mental health tool rests on deploying forms of 'strategic universality' that downplay potential challenges relating to cultural relativism, acceptable forms of evidence, complexity, and local context. Setting aside the many critiques of such strategic universality, what is left unaddressed is a certain **environmental, institutional, or political relativism**. **Considerable discussion across the focus groups**

explored the lack of 'fit' with detention contexts, more generally. This related to the workload conditions for screening (dozens, sometimes hundreds of detainees without medical records, etc. arriving at the same time), security and confidentiality concerns, and more. The need for **bespoke solutions for screening and diagnosis tools is thus clear.**

9.2 CRITIQUES OF THE E-MHGAP-IG

The following is a non-exhaustive synthesis of the main critiques or queries that participants raised vis-à-vis the use of the e-mhGAP:

- As already known, the current lack of functionality on Android devices was discussed as a key limit to the technology;
- The **time-consuming nature of the application** was discussed across the focus groups. This includes **time to administer particular modules**, which was sometimes felt to be too long and **the number of modules themselves (e.g. the different conditions with different questions across the app)**. Running each model would likely take a very long time, especially in the scenario used for the focus groups (imagining dozens/hundreds of detainees arriving at the same time);
    - While **training** can decrease the time it will take to understand the application, this will not affect the screening time necessarily;
        - In one case, participants noted that it is possible to 'rapid fire' the questions listed in each section to a 'fake patient' in such a scenario, and for them to give rapid responses, but this does not reflect the reality of screening on the ground, and especially in detention contexts;
        - In most cases, including some role-played during the exercise, considerably more time is required to screen using the tool, given the reality of posing questions to distressed individuals.
    - This reflects the fact that the (e-)mhGAP-IG is a relatively **high-intensity intervention,** that echoes traditional non-digital diagnostic methods, without an automated component (see above). It also reflects the fact that **some prior knowledge of individuals and their medical status and history** seems to be expected (see below).
- French language is a potential issue; it would be preferable (depending on those administering diagnostics) that it be translated into Lingala, Swahili, or other local languages. It was noted that this might be possible also at a user-level (e.g. providing on-the-fly translations);
- The relative 'complexity' of the application was noted by numerous participants, meant in the following senses:
    - There is **too much text** in much of the application, reflecting it being a digitized version of a paper tool;
    - The 'questions' are sometimes rather too long. Over time, a trained medical professional would adapt to this, but it depends on training in the app *and* prior diagnostic training, and even with such adaptation the application would then become immaterial;
    - The app is essentially a digital book;
    - There are **too many screening options** (see above).
- Does this app truly diagnose?
    - This question came about in numerous groups. The application rests on the intuition of practitioners and/or their prior training to provide diagnosis. It itself is **relatively 'passive'** in the clinical support it provides;
    - This creates numerous issues:
        - Statistical precision is lacking, in the sense that relatively little precision is given on the level of severity of a condition;

- Data confidentiality and security was noted as potential detention-related issue. The application, at present, does not store data, but if it was to do so this would raise confidentiality concerns. Equally, in general in a prison context, more attention would need to given to the **requirements of detention authorities.**

- In general, participants thought the **design of the application was quite good** (despite there being too much text, see above, etc.). Nonetheless, they did perceive potential issues in using a smartphone to screen patients, including some suspicion over the purpose of the device, and the way it might interrupt normal forms of human interaction;

- The **application is poorly 'contextualized'** – it is *too* universal;
    - This was meant, first, vis-à-vis the DRC itself, where numerous 'cultural' issues were noted – the expectation of longer conversations, the local understanding of mental health, the issue of language, etc.
    - Second, this referred to the detention and prison context itself. It was felt that **the questions and screening elements might need to be adapted to specific detention contexts.** Equally, data confidentiality, security, and authority buy-in was discussed.

- The **problem of temporality** was discussed at different points. This complexified the idea of screening 1) 'on entry' to detention, 2) during detention, and 3) 'on exit' from detention. For example, it was discussed how it is not clear what the moment of 'detention' refers to. Does this include immediate detention by the police or authorities, time spent in judicial detention facilities, etc., or other elements that are likely to traumatize someone before their arrival in a 'main' prison facility. It also referred to pre-existing conditions and how these can/cannot be tracked using an application like this (due to e.g. a lack of medical records).

- The **importance of a 'human' discussion** was explored. This referred to both the standardized and relatively sanitized nature of the screening and assessment process, which it was said might pose issues in gaining patient trust. This also related to language and other 'local' issues. More generally, the problem of diagnosis without having a clear 'real-world' understanding of the patient, their life, their family, and their difficulties – in the full ecology of psychosocial complexity – was discussed. While rapid screening and triage was seen as important for especially acute cases, it was discussed how it would be important if possible to integrate a more holistic understanding of mental health and psychosocial difficulties, especially if referral and treatment is to follow.

- The 'device' used to administer screening and triage assessments such as these was explored in two focus groups. In particular, **whether or not a smartphone was the best option**. It was mentioned, for example, that a tablet might be better, and better 'fit' with clinical contexts, increase the UX of both the medical professional and the patient and provide more openness. Others also suggested that this might be better integrated into a more traditional computer terminal (e.g. not a mobile app), so that it could have better integration into existing systems, and also better meet the security and confidentiality requirements of detention officials (though issues relating to power availability were a counterpoint).

- While the application is designed to assist medical professionals who are not well trained in mental-health related issues, it would still seem to risk **excluding certain users**, especially in detention contexts (such as prison staff themselves).

10.
ANNOTATED BIBLIOGRAPHY

A. MENTAL HEALTH IN PRISONS IN LMIC

Keywords	Citation	Year
Forensic health, global justice, in LMICs.	Smith, A., Ogunwale, A., Moura, H. F., Bhugra, D., Ventriglio, A., & Liebrenz, M. (2024). Mental health and justice beyond borders: Global crises, sociopolitical determinants, and contemporary practices in forensic psychiatry. *International Review of Psychiatry*, *36*(7), 784–793. https://doi.org/10.1080/09540261.2024.2346076	2024
Mental health in prisons in general	Nindeng, A. N. (2024). Mental health and well-being in prisons and places of detention. International Journal of Prison Health.	2024
Malawi, Qualitative Study	Van Hout, M. C., Kaima, R., Magwejani, C., Kasunda, V., Nyson, K., Khoviwa, P., ... & Kewley, S. (2024). "Prison life can make you go crazy": Insights into the situation for	2024
Mental health children living in detention	Prakash, P., Khurana, P., Gupta, M., Madabushi, J. S., & PRAKASH, P. (2024). Behind Prison Walls: Critical Overview of the Mental Health Trajectories of Children Living With Incarcerated Mothers. Cureus, 16(7).	2024
Screening, Colombia, prisons	Guyader-Cohen, M. Á. C., Cadena-Mantilla, G., & Ibáñez-Pinilla, E. A. (2023). Mental Health Screening of People Deprived of Liberty, Analyzed Through the Brief Jail Mental Health Screening (BJMHS) in Three Colombian Establishments. *MedUNAB*, *26*(2), 138-151.	2023
Colombia, Screening	Guyader-Cohen, M. Á. C., Cadena-Mantilla, G., & Ibáñez-Pinilla, E. A. (2023). Mental Health Screening of People Deprived of Liberty, Analyzed Through the Brief Jail Mental Health Screening (BJMHS) in Three Colombian Establishments. *MedUNAB*, *26*(2), 138-151.	2023
Review of general risks in LMICs.	Hill, K., Wainwright, V., Stevenson, C., Senior, J., Robinson, C., & Shaw, J. (2022). Prevalence of mental health and suicide risk in prisons in low- and middle-income countries: a rapid review. *The Journal of Forensic Psychiatry & Psychology*, *33*(1), 37–52. https://doi.org/10.1080/14789949.2021.2016891	2022
Kinshasa, Psychosocial	Jean Donatus BAHATI SHABANYERE, Ursule BISENO IWAYI, John LEFI NDOSI. (2022). Problématique de la prise en charge psychosociale des détenus du centre pénitentiaires et de rééducation de Kinshasa. Akofena 2 (8).	2022
Forensic mental health, Africa, general	Ogunwale, A., Ogunlesi, A., Shepherd, S. M., Serpa, K. I., & Singh, J. P. (Eds.). (2021). The handbook of forensic mental health in Africa. Routledge.	2021
Rwanda, psychosocial rehabilitation	Ndwanyi, M. G. (2021). The role of psychosocial support in rehabilitation of inmates: a case of Ngoma prison (Doctoral dissertation, University of Rwanda).	2021
Severe disorders, prisons, LMICs	Gureje, O., & Abdulmalik, J. (2019). Severe mental disorders among prisoners in low-income and middle-income countries: reaching the difficult to reach. The Lancet global health, 7(4), e392-e393.	2019

Africa, meta-review	Lovett, A., Kwon, H. R., Kidia, K., Machando, D., Crooks, M., Fricchione, G., ... & Jack, H. E. (2019). Mental health of people detained within the justice system in Africa: systematic review and meta-analysis. International Journal of Mental Health Systems, 13, 1-41.	2019
Scoping review, juveline, Africa	Van Hout, M. C., & Mhlanga-Gunda, R. (2019). Prison health situation and health rights of young people incarcerated in sub-Saharan African prisons and detention centres: a scoping review of extant literature. BMC international health and human rights, 19, 1-16.	2019
Ethiopia, depression	Alemayehu, F., Ambaw, F., & Gutema, H. (2019). Depression and associated factors among prisoners in Bahir Dar Prison, Ethiopia. BMC psychiatry, 19, 1-7.	2019
Prison; Mbuji-Mayi; qualtiy of life perception	Kalonji, M. P. G., Ngongo, L. O., Ilunga, F. I., Albert, A., & Giet, D. (2017). Quality of life perception by inmates in the central prison of Mbuji-Mayi, Democratic Republic of Congo. *International Journal of Medical Research & Health Sciences*, *6*(12), 42-48.	2017
Nigeria, depression, anxiety	Osasona, S. O., & Koleoso, O. N. (2015). Prevalence and correlates of depression and anxiety disorder in a sample of inmates in a Nigerian prison. The International Journal of Psychiatry in Medicine, 50(2), 203-218	2015
Forensic psychology in Africa	Ogunlesi, A. O., Ogunwale, A., De Wet, P., Roos, L., & Kaliski, S. (2012). Forensic psychiatry in Africa: Prospects and challenges: Guest editorial. *African journal of psychiatry*, *15*(1), 3-7.	2012
Drug use, prison, Nigeria	Ogunwale, A., Ogunlesi, A. O., & Akinhanmi, A. O. (2012). Psychoactive Substance Use Among Young Offenders in a Nigerian Correctional Facility: A Comparative Analysis. *International Journal of Forensic Mental Health*, *11*(2), 91–101. https://doi.org/10.1080/14999013.2012.688090	2012
Congo, Psychopathy, Prisons	On'okoko, M. O. (2011). *Assessing Psychopathy Among Male Prisoners in the Democratic Republic of Congo: A Cross-cultural Analysis in a Post-crisis Setting*. McGill University (Canada).	2011
African perspective	Asuni, T. (1986). Mental Health in Prison-The African Perspective. International journal of offender therapy and comparative criminology, 30(1), 1-9.	1986
Mental health beds available, Africa over time	Mundt AP, Langerfeldt SD, Maphisa JM, Sourabié O, Yongsi BN, Serri ER, Bukasa Tshilonda JC, Te JH, Bitta MA, Mathe L, Liwimbi O, Dos Santos PF, Atilola O, Jansen S, Diegane Tine JA, Akran C, Jalloh A, Kagee A, Van Wyk ES, Forry JB, Imasiku ML, Chigiji H, Priebe S. Changes in rates of psychiatric beds and prison populations in sub-Saharan Africa from 1990 to 2020. J Glob Health. 2022 Sep 3;12:04054. doi: 10.7189/jogh.12.04054. PMID: 36056592; PMCID: PMC9440375.	2022

B. MENTAL HEALTH IN PRISONS IN GENERAL

Keywords	Citation	Year
Psychosocial interventions in prison, systematic review	Thekkumkara, S. N., Jagannathan, A., Muliyala, K. P., & Murthy, P. (2022). Psychosocial interventions for prisoners with mental and substance use disorders: A systematic review. Indian Journal of Psychological Medicine, 44(3), 211-217.	2022
Mental and physical health, prison, review	Favril, L., Rich, J. D., Hard, J., & Fazel, S. (2024). Mental and physical health morbidity among people in prisons: an umbrella review. The Lancet Public Health, 9(4), e250-e260.	2024
Clinical decision making, forensic mental health	Griffith, J. J. (2020). *Beyond Prediction: Supporting Clinical Decision Making in the Prevention of Aggression in a Forensic Mental Health Setting* (Doctoral dissertation, Swinburne).	2020
Treatment patterns post-screening, review	Martin, M. S., Potter, B. K., Crocker, A. G., Wells, G. A., Grace, R. M., & Colman, I. (2018). Mental health treatment patterns following screening at intake to prison. *Journal of Consulting and Clinical Psychology*, *86*(1), 15.	2018
Interventions, systematic review, prison	Hailemariam, M., Bustos, T. E., Montgomery, B. W., Brown, G., Tefera, G., Adaji, R., ... & Johnson, J. E. (2024). Mental health interventions for individuals with serious mental illness in the criminal legal system: a systematic review. *BMC psychiatry*, *24*(1), 199.	2024
Mental health, prison, 43 countries, meta analysis	Emilian, C., Al-Juffali, N., & Fazel, S. (2025). Prevalence of severe mental illness among people in prison across 43 countries: a systematic review and meta-analysis. *The Lancet Public Health*, *10*(2), e97-e110.	2025

C. CONGO SPECIFIC LITERATURE

Keywords	Citation	Year
Kasai, post-conflict	Seekles, M. L., Kadima, J. K., Omumbu, P. O., Kukola, J. K., Kim, J. J., Bulambo, C. B., ... & Dean, L. (2025). Prevalence of mental health conditions in post-conflict Kasai Province, Democratic Republic of the Congo: A repeated, cross-sectional study. PLOS Global Public Health, 5(1), e0004057.	2025
Religion, mental health	Vivalya, B. M. N., Vagheni, M. M., Piripiri, A. L., & Mbeva, J. B. K. (2025). Religion and mental health seeking behaviors in war-tone zones of the Democratic Republic of the Congo. The International Journal of Psychiatry in Medicine, 00912174251316784	2025
Integrating primary care, MHGap, Case Studies	Mukala Mayoyo, E., Criel, B., Labat, A., Coppieters, Y., & Chenge, F. (2025). Integrating Mental Health Services into Primary Care Settings: A Multiple Case Study of Congolese Experiences testing the Feasibility of the WHO's mental health Gap Action Programme. Preprints. https://doi.org/10.20944/preprints202501.0604.v1	2025
Congolese Mental Health Providers, Practices, Gaps, Obstacles	ter Wiel, A., & Slegh, H. (2024). Practices of Congolese Mental Health and Psychosocial Support Providers: A Qualitative Study on Gaps and Obstacles. *Intervention Journal of Mental Health and Psychosocial Support in Conflict Affected Areas*, *22*(2), 108-117.	2024
Mental health services, Congo, barriers, facilitators, primary care	Mukala Mayoyo, E., Chenge, F., Sow, A., Criel, B., Michielsen, J., Van den Broeck, K., & Coppieters, Y. (2024). Health system facilitators and barriers to the integration of mental health services into primary care in the Democratic Republic of the Congo: a multimethod study. *BMC Primary Care*, *25*(1), 214.	2024
Sexual violence, scoping review	Andersen, I., & Buttigieg, F. (2024). Mental Health and Psychosocial Support for Victims/Survivors of Sexual Violence in Conflict and Emergency Settings: A Scoping Review. Intervention Journal of Mental Health and Psychosocial Support in Conflict Affected Areas, 22(1), 22-30.	2024
Facilitators, barriers, integration, primary care	Mukala Mayoyo, E., Chenge, F., Sow, A., Criel, B., Michielsen, J., Van den Broeck, K., & Coppieters, Y. (2024). Health system facilitators and barriers to the integration of mental health services into primary care in the Democratic Republic of the Congo: a multimethod study. BMC Primary Care, 25(1), 214.	2024
Indigenous knowledge, mental health, congo, Goma	Kyolo, S. K., Bbosa, G. S., Odda, J., Mwebaza, N., Kibendelwa, Z. T., Nakasujja, N., & Katuura, E. (2023). Indigenous knowledge and perception toward mental illnesses within Goma city in Democratic Republic of Congo.	2023
Trauma, Congo, Kivu, multiplicity	Taylor, S., Mavinga, L., & Bashiga, M. (2023). Unbracketing the multiplicity of trauma in North Kivu, Democratic Republic of Congo. *Singapore Journal of Tropical Geography*, *44*(2), 339-355.	2023
Congo, services, mental health, urban, qualitative	Mukala Mayoyo, E., Criel, B., Sow, A., Coppieters, Y., & Chenge, F. (2023). Understanding the mix of services for mental health care in urban DR Congo: a qualitative descriptive study. *BMC health services research*, *23*(1), 1206.	2023
Lubum, Mental Health	Mukala Mayoyo, E., Criel, B., Michielsen, J., Chuy, D., Coppieters, Y., & Chenge, F. (2023). Mental health care in the city of Lubumbashi, Democratic Republic of the Congo: Analysis of demand, supply and operational response capacity of the health district of Tshamilemba. Plos one, 18(4), e0280089.	2023

Physical rehabilitation, cohort study	Andersen, Ida, et al. "Mental health and psychosocial support during physical rehabilitation in Eastern Democratic Republic of Congo: a retrospective cohort study." Disability and Rehabilitation 45.17 (2023): 2777-2786.	2023
Kinshasa, psychosocial, makala prison	Jean Donatus BAHATI SHABANYERE, Ursule BISENO IWAYI, John LEFI NDOSI. (2022). Problématique de la prise en charge psychosociale des détenus du centre pénitentiaires et de rééducation de Kinshasa. Akofena 2 (8).	2022
Congolese practices, psychosocial, obstacles	At, W., & Slegh, H. (2022). Practices of Congolese mental health and psychosocial support providers: a qualitative study on challenges and obstacles.	2022
Integration primary care	Mayoyo, E. M., van de Put, W., Van Belle, S., van Mierlo, B., & Criel, B. (2021). Intégration de la santé mentale dans les services de soins de santé primaires en République démocratique du Congo. Sante Publique, 33(1), 77-87.	2021
Psychosocial and mental health problems, Congo, refugees	Chiumento, A., Rutayisire, T., Sarabwe, E., Hasan, M. T., Kasujja, R., Nabirinde, R., ... & White, R. G. (2020). Exploring the mental health and psychosocial problems of Congolese refugees living in refugee settings in Rwanda and Uganda: a rapid qualitative study. *Conflict and Health*, *14*, 1-21.	2020
Epistemological pluralism, RDC	Taylor, S. (2017). Making space for restoration: epistemological pluralism within mental health interventions in Kinshasa, Democratic Republic of Congo. Area, 49(3), 342-	2017
Psychopathy, Congo, prisoners, post-crisis	On'okoko, M. O. (2011). *Assessing Psychopathy Among Male Prisoners in the Democratic Republic of Congo: A Cross-cultural Analysis in a Post-crisis Setting*. McGill University (Canada).	2011
Mental health outcomes; literacy; review; Congo	Ngamaba, K. H., Lombo, L. S., Makopa, I. K., Webber, M., Liuta, J. M., Madinga, J. N., ... & Heap, C. (2024). Mental health outcomes, literacy and service provision in low-and middle-income settings: a systematic review of the Democratic Republic of the Congo. *npj Mental Health Research*, *3*(1), 9.	2024
Prison; Mbuji-Mayi; qualtiy of life perception	Kalonji, M. P. G., Ngongo, L. O., Ilunga, F. I., Albert, A., & Giet, D. (2017). Quality of life perception by inmates in the central prison of Mbuji-Mayi, Democratic Republic of Congo. *International Journal of Medical Research & Health Sciences*, *6*(12), 42-48.	2017
Maternal and child health, detention, women, prison	Expérience des femmes en détention sur la prise en charge des problèmes de sante maternelle et infantile en milieu carcéral à Kinshasa. (2022). REVUE DES SCIENCES DE LA SANTE, 1(1), 41-50. https://doi.org/10.71004/rss.022.v1.i1.09	2022
Sexual violence, digital tech, mental health	Peguy Ndona Nkunku, Détection et prise en charge des troubles anxiodépressifs chez les femmes victimes des violences sexuelles dans l'Est de la République Démocratique du Congo, 2022	2022
Digital tech, mental health, africa, congo	Péguy Nkunku Alain Pesage Magloire Mpembi (2023). Accès aux technologies digitales pour le traitement ou la gestion thérapeutique des troubles anxieux et dépressifs en Afrique : Une revue systématique de la littérature	2023
Mental health, DRC, post-crisis	On'okoko, M. O., Jenkins, R., Miezi, S. M. M., Andjafono, D. O. L. E., & Mushidi, I. M. (2010). Mental health in the Democratic Republic of Congo: a post-crisis country challenge. *International Psychiatry*, *7*(2), 41-43.	2010

Kinshasa, adolescents, mental difficulties	Ndjukendi, A., Okitundu, D., N'situ, A., Mpaka, D., Lukeba, T., Ngoma, V., ... & Falissard, B. (2017). Adolescents en situation difficile à Kinshasa: quelles stratégies d'adaptation?. *L'Évolution Psychiatrique*, *82*(1), 75-87.	2017
History, first neuro-psychology centre DRC	Tshimbombu, T. N., Song, S. H., Rojas-Soto, D. M., & Daniel, O. L. E. A. (2022). Historical overview of the only neuro-psycho-pathology center in the Democratic Republic of Congo. *World Neurosurgery*, *161*, 72-74.	2022
Kivu, childhood trauma, psychological relapse	Vivalya, B. M. N., Vagheni, M. M., Piripiri, A. L., Masuka, R. K., Omba, A. N., Mankubu, A. N., ... & Kitoko, G. M. B. (2022). Prevalence and factors associated with relapse and long hospital stay among adult psychiatric patients with a history of childhood trauma. *Psychiatry Research*, *316*, 114745.	2022

D. COLOMBIA SPECIFIC LITERATURE

Keywords	Citation	Year
Mental health, ex-FARC, peace process	Idrobo, F., Hessel, P., Harker, A., Evans-Lacko, S., & Avendaño, M. (2018). Poor mental health of victims and former FARC members represents a significant challenge for peace process in Colombia. *The Lancet Psychiatry*, *5*(6), 467-468.	2018
Mental health, prison, Colombia, screening	Guyader-Cohen, M. Á. C., Cadena-Mantilla, G., & Ibáñez-Pinilla, E. A. (2023). Mental Health Screening of People Deprived of Liberty, Analyzed Through the Brief Jail Mental Health Screening (BJMHS) in Three Colombian Establishments. *MedUNAB*, *26*(2), 138-151.	2023
Colombian psychology	Mora Gámez, F. A. (2012). *Colombian Psychology: Knowledge, Technique and Controversies; Reconstructions from Social Studies of Science and Technology* (Doctoral dissertation).	2012
Colombian armed conflict, promotion mental health, scoping	Ballesteros, L. M. G., Mojica, L. E., Marín, J. C., Ortiz, A. F., Ponce, M. V., Pérez-Lalinde, S., ... & Álvarez, A. C. (2024). Mental Health Promotion in Victims of Colombian Armed conflict: a Scoping Review. *medRxiv*, 2024-10.	2024
Prison crisis, Colombia, psychology	Granados, L. Y. H., Rubio, G. A. E., & Jaimes, M. C. (2023). THE PERSISTENCE OF THE PRISON CRISIS IN COLOMBIA. *Journal of Positive Psychology and Wellbeing*, *7*(1), 49-62.	2023

E. MENTAL HEALTH IN LMIC IN GENERAL

Keywords	Citation	Year
Screening, mental disorders, systematic review, LMIC	Ali, G. C., Ryan, G., & De Silva, M. J. (2016). Validated screening tools for common mental disorders in low and middle income countries: a systematic review. *PloS one*, *11*(6), e0156939.	2016
Africa, juvenile, mental health, systematic review	Jörns-Presentati, A., Napp, A. K., Dessauvagie, A. S., Stein, D. J., Jonker, D., Breet, E., ... & Groen, G. (2021). The prevalence of mental health problems in sub-Saharan adolescents: A systematic review. *Plos one*, *16*(5), e0251689.	2021
Psychological assessment, South Africa	Laher, S. (2024). Advancing an agenda for psychological assessment in South Africa. *South African Journal of Psychology*, *54*(4), 515-530.	2024
Africa, students, computerized adaptive testing	Oladele, J. I. (2025). Computerised adaptive method for assessing university undergraduates' mental well-being within an African context: An open-source set-up with Concerto. *MethodsX*, *14*, 103140.	2025
Barriers, mental health services, LMICs	Saraceno, B., van Ommeren, M., Batniji, R., Cohen, A., Gureje, O., Mahoney, J., ... & Underhill, C. (2007). Barriers to improvement of mental health services in low-income and middle-income countries. *The Lancet*, *370*(9593), 1164-1174.	2007
Mental health children living in detention	Prakash, P., Khurana, P., Gupta, M., Madabushi, J. S., & PRAKASH, P. (2024). Behind Prison Walls: Critical Overview of the Mental Health Trajectories of Children Living With Incarcerated Mothers. Cureus, 16(7).	2024
Sexual violence, scoping review	Andersen, I., & Buttigieg, F. (2024). Mental Health and Psychosocial Support for Victims/Survivors of Sexual Violence in Conflict and Emergency Settings: A Scoping Review. Intervention Journal of Mental Health and Psychosocial Support in Conflict Affected Areas, 22(1), 22-30.	2024
Malawi, mental health, HIV, depression	Udedi, M., Stockton, M. A., Kulisewa, K., Hosseinipour, M. C., Gaynes, B. N., Mphonda, S. M., ... & Pence, B. W. (2018). Integrating depression management into HIV primary care in central Malawi: the implementation of a pilot capacity building program. BMC health services research, 18, 1-12.	2018
Depression, diabetes, systematic review	Udedi, M., Pence, B., Kauye, F., & Muula, A. S. (2018). The effect of depression management on diabetes and hypertension outcomes in low-and middle-income countries: a systematic review protocol. Systematic Reviews, 7, 1-5.	2018
Detection, Primary Care, Mental Health, LMIC	Fekadu, A., Demissie, M., Birhane, R., Medhin, G., Bitew, T., Hailemariam, M., ... & Prince, M. (2022). Under detection of depression in primary care settings in low and middle-income countries: a systematic review and meta-analysis. *Systematic Reviews*, *11*(1), 21.	2022
Treatment gap, critique, Rwanda	Jansen, S., White, R., Hogwood, J., Jansen, A., Gishoma, D., Mukamana, D., & Richters, A. (2015). The "treatment gap" in global mental health reconsidered: sociotherapy for collective trauma in Rwanda. *European Journal of Psychotraumatology*, *6*(1), 28706.	2015

F. CDSS AND DIGITAL INTERVENTIONS (PRISON OR NOT)

Keywords	Citation	Year
Africa, students, computerized adaptive testing	Oladele, J. I. (2025). Computerised adaptive method for assessing university undergraduates' mental well-being within an African context: An open-source set-up with Concerto. *MethodsX*, *14*, 103140.	2025
CDSS, helpline services, review	Gu, Y., Andargoli, A. E., Mackelprang, J. L., & Meyer, D. (2024). Design and implementation of clinical decision support systems in mental health helpline Services: A systematic review. International journal of medical informatics, 105416.	2024
Prisons, screening, computerized adaptive testing	Xu, Z., Pan, Z., Wang, Y., Zhang, Y., & Leng, P. (2024). Research on a machine learning-based adaptive and efficient screening model for psychological symptoms of community correctional prisoners. *Scientific Reports*, *14*(1), 9890.	2024
Mobile apps, natural disaster, response	Ezeonu, N. A., Hertelendy, A. J., Adu, M. K., Kung, J. Y., Itanyi, I. U., Dias, R. D. L., ... & Eboreime, E. (2024). Mobile Apps to Support Mental Health Response in Natural Disasters: Scoping Review. *Journal of medical internet research*, *26*.	2024
Digital app, south africa, university students	Mudau, T., Jithoo, V., & Dietrich, J. (2024). Exploring the demand, practicality, and acceptability of a mental health application intervention for students at a South African university. *South African Journal of Psychology*, *54*(2), 171-184.	2024
Ethiopia, mobile apps, feature preferences	Guracho, Y. D., Thomas, S. J., & Win, K. T. (2024). Mobile mental health application use, and app feature preferences among individuals with mental disorders in Ethiopia: A cross-sectional survey. *International Journal of Medical Informatics*, *192*, 105628.	2024
PHQ-9 Remote Digital Screening	Carroll, M. K., Taylor, K., Subramaniam, H. L., Wong, C., Nelson, B. W., Plowman, R. S., ... & Nunes, J. C. (2024). PCR37 Differences in PHQ-9 Scores Based on Remote Digital Versus in-Person Administration: Findings From the Project Baseline Health Study. Value in Health, 27(6), S302.	2024
CDSS Artificial Intelligence	Golden, G., Popescu, C., Israel, S., Perlman, K., Armstrong, C., Fratila, R., ... & Benrimoh, D. (2024). Applying artificial intelligence to clinical decision support in mental health: what have we learned?. *Health Policy and Technology*, *13*(2), 100844.	2024
Digital Technology, Forensic Mental Health	Mohan, D. (2023). Digital technology: Transforming delivery of forensic mental healthcare. Criminal Behaviour & Mental Health, 33(3).	2023
Technology, forensic mental health	Kirschstein, M. A., Batastini, A. B., Singh, J. P., & Graf, M. (2023). Technological innovations in forensic and correctional mental health: An introduction to the special issue. Criminal Justice and Behavior, 50(2), 167-174	2023
Emerging technologies, forensic mental health	Kirschstein, M. A., Singh, J. P., Rossegger, A., Endrass, J., & Graf, M. (2023). International survey on the use of emerging technologies among forensic and correctional mental health professionals. Criminal Justice and Behavior, 50(2), 175-196.	2023
AI, Mentally Ill Prisoners	Pokhriyal, S., Bahuguna, R., Memoria, M., & Kumar, R. (2023, May). Application of Artificial Intelligence Based Techniques on Mentally Ill Prisoners. In 2023 International Conference on Advancement in Computation & Computer Technologies (InCACCT) (pp. 58-62). IEEE	2023

Africa, digital technologies, mental health, review	Nkunku, P., Pesage, A., Mpembi, M., & Nkunku, P. (2023). Accès aux technologies digitales pour le traitement ou la gestion thérapeutique des troubles anxieux et dépressifs en Afrique: une revue systématique de la littérature Access to digital technologies for the treatment or therapeutic management of anxiety and depressive disorders in Africa: a systematic review of literature. *Ann. Afr. Med*, *16*(3).	2023
Screening, app, juvenile, primary care	Groen, G., Jörns-Presentati, A., Dessauvagie, A., Seedat, S., Van Den Heuvel, L. L., Suliman, S., ... & Lahti, M. (2022). Development of a mobile application for detection of adolescent mental health problems and feasibility assessment with primary health care workers. Issues in mental health nursing, 43(11), 1046-1055.	2022
Human centered design, digital mental health	Vial, S., Boudhraâ, S., & Dumont, M. (2022). Human-centered design approaches in digital mental health interventions: exploratory mapping review. *JMIR mental health*, *9*(6), e35591.	2022
Digital, natural disaster, screening	Heinz, A. J., Wiltsey-Stirman, S., Jaworski, B. K., Sharin, T., Rhodes, L., Steinmetz, S., ... & McGovern, M. (2022). Feasibility and preliminary efficacy of a public mobile app to reduce symptoms of postdisaster distress in adolescent wildfire survivors: Sonoma rises. *Psychological services*, *19*(S2), 67.	2022
Digital prison rehabilitation	Zivanai, E., & Mahlangu, G. (2022). Digital prison rehabilitation and successful re-entry into a digital society: A systematic literature review on the new reality on prison rehabilitation. Cogent Social Sciences, 8(1), 2116809	2022
Barriers tech adoption in prisons	Link, T. C., & Reece, B. (2021). Barriers to the adoption of technological innovations in corrections: A review and case study. *International journal of offender therapy and comparative criminology*, *65*(2-3), 262-281.	2021
Online, screening, depresssion, south africa	Hassem, T. (2021). Establishing the content validity of an online depression screening tool for South Africa. *African Journal of Psychological Assessment*, *3*, 10.	2021
Mobile screening, PHQ-9	Kim, S., & Lee, K. (2021). Screening for depression in mobile devices using Patient Health Questionnaire-9 (PHQ-9) data: a diagnostic meta-analysis via machine learning methods. Neuropsychiatric Disease and Treatment, 3415-3430.	2021
CDSS development, general.	Kemppinen, J. (2020). The development and implementation of the clinical decision support system for integrated mental and addiction care.	2020
CDSS, Forensic Medicine, Prison	Griffith, J. J. (2020). *Beyond Prediction: Supporting Clinical Decision Making in the Prevention of Aggression in a Forensic Mental Health Setting* (Doctoral dissertation, Swinburne).	2020
MEGA, mobile app, South Africa, Zambia	Lahti, M., Groen, G., Mwape, L., Korhonen, J., Breet, E., Chapima, F., ... & Grobler, G. (2020). Design and development process of a youth depression screening m-health application for primary health care workers in South Africa and Zambia: an overview of the MEGA project. *Issues in mental health nursing*, *41*(1), 24-30.	2020
Digital technology, LMICs	Naslund, J. A., Aschbrenner, K. A., Araya, R., Marsch, L. A., Unützer, J., Patel, V., & Bartels, S. J. (2017). Digital technology for treating and preventing mental disorders in low-income and middle-income countries: a narrative review of the literature. The Lancet Psychiatry, 4(6), 486-500.	2017
Screening, substantive abuse, digital	Wolff, N., & Shi, J. (2015). Screening for substance use disorder among incarcerated men with the Alcohol, Smoking, Substance Involvement Screening Test (ASSIST): a comparative analysis of computer-administered and interviewer-administered modalities. Journal of substance abuse treatment, 53, 22-32.	2015

Digital app, post-disaster	Seligman J, Felder SS, Robinson ME. Substance Abuse and Mental Health Services Administration (SAMHSA) Behavioral Health Disaster Response App. Disaster Med Public Health Prep. 2015 Oct;9(5):516-8. doi: 10.1017/dmp.2015.84. Epub 2015 Jul 13. PMID: 26165522.	2015
South Africa, mobile phones	Norris, L., Swartz, L., & Tomlinson, M. (2013). Mobile phone technology for improved mental health care in South Africa: Possibilities and challenges. South African Journal of Psychology, 43(3), 379-388.	2013
Computerized Adaptive Testing	Meijer, R. R., & Nering, M. L. (1999). Computerized adaptive testing: Overview and introduction. *Applied psychological measurement*, *23*(3), 187-194.	1999
Mobile health, innovation, image-based, review	Wallis, L., Hasselberg, M., Barkman, C., Bogoch, I., Broomhead, S., Dumont, G., ... & Laflamme, L. (2017). A roadmap for the implementation of mHealth innovations for image-based diagnostic support in clinical and public-health settings: a focus on front-line health workers and health-system organizations. *Global health action*, *10*(sup3), 1340254.	2017
Portable devices, IoT, healthcare monitoring	Rajendran, S., Porwal, A., Anjali, K., Anvaya, & Anuradha, R. J. (2024). Portable IoT Devices in Healthcare for Health Monitoring and Diagnostics. *Internet of Things in Bioelectronics: Emerging Technologies and Applications*, 263-296.	2024
Efficacy, CDSS, systematic review	Hak, F., Guimarães, T., & Santos, M. (2022). Towards effective clinical decision support systems: A systematic review. *PloS one*, *17*(8), e0272846.	2022
Forensic e-mental health, review, priorities	Kois, L. E., Cox, J., & Peck, A. T. (2021). Forensic e-mental health: Review, research priorities, and policy directions. *Psychology, Public Policy, and Law*, *27*(1), 1.	2021
MHGapp App	Luitel, N. P., Pudasaini, K., Pokhrel, P., Lamichhane, B., Gautam, K., Adhikari, S., ... & Carswell, K. (2023). Development and functioning of the mobile app-based mh-GAP intervention guide in detection and treatment of people with mental health conditions in primary healthcare settings in Nepal. *Cambridge Prisms: Global Mental Health*, *10*, e90.	2023
MHGapp, Nigeria, User Studies	Ojagbemi, A., Daley, S., Kola, L., Taylor Salisbury, T., Feeney, Y., Makhmud, A., ... & Gureje, O. (2022). Perception of providers on use of the WHO mental health Gap Action Programme-Intervention Guide (mhGAP-IG) electronic version and smartphone-based clinical guidance in Nigerian primary care settings. *BMC Primary Care*, *23*(1), 264.	2022
Computerized Adaptive Testing	Gibbons, R. D., Weiss, D. J., Pilkonis, P. A., Frank, E., Moore, T., Kim, J. B., & Kupfer, D. J. (2012). Development of a computerized adaptive test for depression. *Archives of general psychiatry*, *69*(11), 1104-1112.	2012
Interdisciplinary, digital technologiesl, global mental health	Kuhn E, Saleem M, Klein T, Köhler C, Fuhr DC, Lahutina S, et al. (2024) Interdisciplinary perspectives on digital technologies for global mental health. PLOS Glob Public Health 4(2): e0002867. https://doi.org/10.1371/journal.pgph.0002867	2024

G. AI IN MENTAL HEALTH

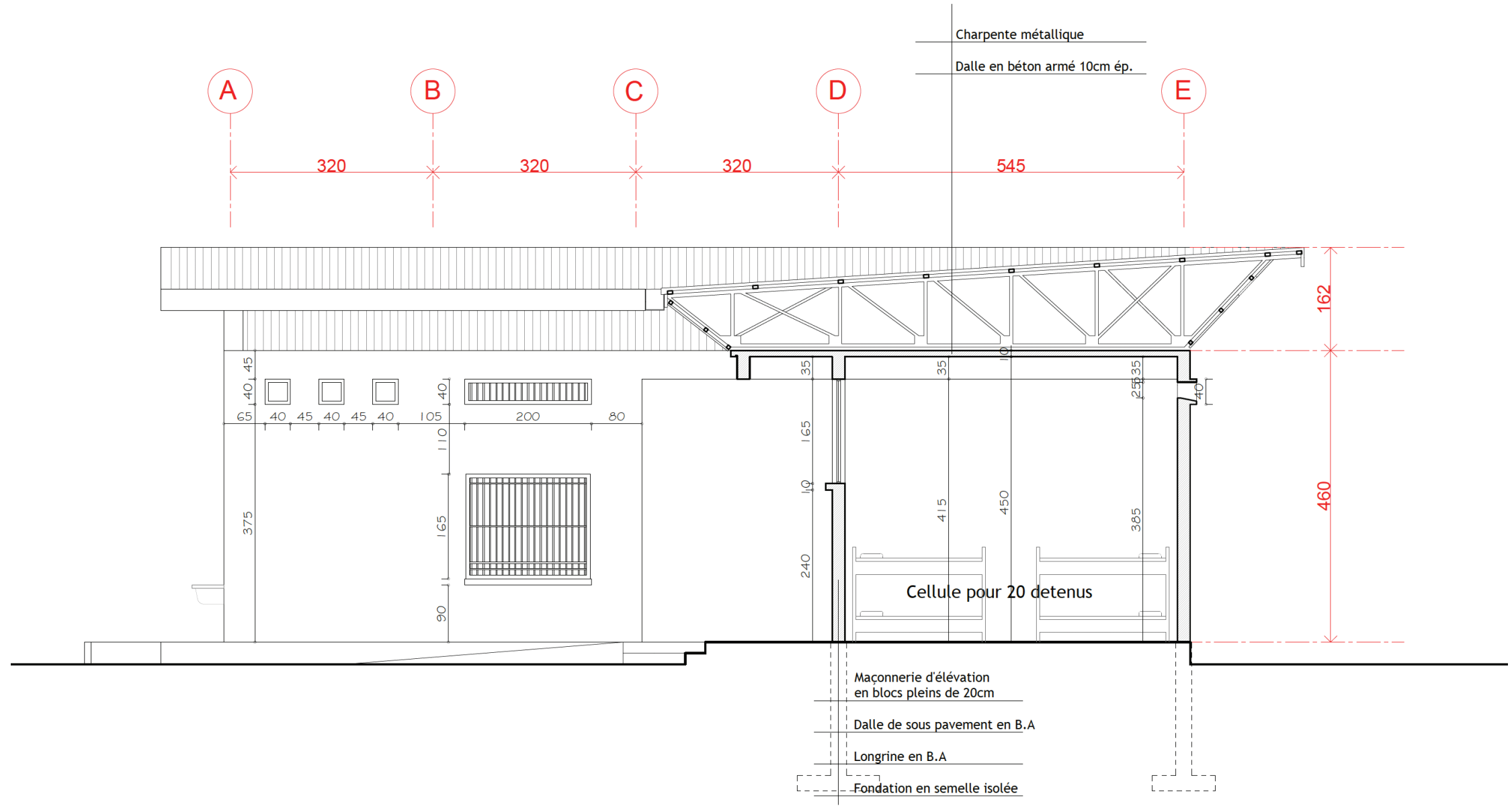
Keywords	Citation	Year
Machine learning, assessment, screening	Colledani, D., Barbaranelli, C., & Anselmi, P. (2025). Fast, smart, and adaptive: using machine learning to optimize mental health assessment and monitor change over time. *Scientific Reports*, *15*(1), 6492.	2025
Nursing, MH, AI	Milasan, L. H., & Scott-Purdy, D. (2025). The Future of Artificial Intelligence in Mental Health Nursing Practice: An Integrative Review. International Journal of Mental Health Nursing, 34(1), e70003.	2025
Automated diagnostics, advantages	Yang, M., & Mori, H. (2024, June). Automated diagnostics and its advantages of AI in mental health. In *International conference on human-computer interaction* (pp. 289-299). Cham: Springer Nature Switzerland.	2024
CDSS Artificial Intelligence	Golden, G., Popescu, C., Israel, S., Perlman, K., Armstrong, C., Fratila, R., ... & Benrimoh, D. (2024). Applying artificial intelligence to clinical decision support in mental health: what have we learned?. *Health Policy and Technology*, *13*(2), 100844.	2024
Screening, machine learning, adaptive	Xu, Z., Pan, Z., Wang, Y., Zhang, Y., & Leng, P. (2024). Research on a machine learning-based adaptive and efficient screening model for psychological symptoms of community correctional prisoners. *Scientific Reports*, *14*(1), 9890.	2024
AI, Mental Health	Zucchetti, A., Nibbio, G., Altieri, L., Bertorni, L., Calzavara-Pinton, I., Invernizzi, E., ... & Vita, A. (2024). Artificial intelligence applications in mental health: the state of the art. Italian Journal of Psychiatry.	2024
AI, Africa	Ephraim, R. K. D., Kotam, G. P., Duah, E., Ghartey, F. N., Mathebula, E. M., & Mashamba-Thompson, T. P. (2024). Application of medical artificial intelligence technology in sub-Saharan Africa: Prospects for medical laboratories. Smart Health, 100505.	2024
Mental health, human interaction	Babu, A., & Joseph, A. P. (2024). Artificial intelligence in mental healthcare: transformative potential vs. the necessity of human interaction. Frontiers in Psychology, 15,	2024
Narrative Review	Thakkar, A., Gupta, A., & De Sousa, A. (2024). Artificial intelligence in positive mental health: a narrative review. Frontiers in Digital Health, 6, 1280235.	2024
Ethics, AI for MH	Saeidnia, H. R., Hashemi Fotami, S. G., Lund, B., & Ghiasi, N. (2024). Ethical considerations in artificial intelligence interventions for mental health and well-being: Ensuring responsible implementation and impact. Social Sciences, 13(7), 381.	2024
Innovation, Tanzania, Challenges	Mwogosi, A., Mambile, C., Shao, D., & Kibinda, N. (2024). AI-driven innovations for enhancing mental health care in Tanzania: opportunities and challenges. Mental Health and Social Inclusion.	2024
Ethics, Africa	Ugar, E. T., & Malele, N. (2024). Designing AI for mental health diagnosis: challenges from sub-Saharan African value-laden judgements on mental health disorders. Journal of Medical Ethics.	2024
Africa, Public Health Surveillance	Tshimula, J. M., Kalengayi, M., Makenga, D., Lilonge, D., Asumani, M., Madiya, D., ... & Kasoro, N. M. (2024). Artificial Intelligence for Public Health Surveillance in Africa: Applications and Opportunities. arXiv preprint arXiv:2408.02575	2024

AI, Mentally Ill Prisoners	Pokhriyal, S., Bahuguna, R., Memoria, M., & Kumar, R. (2023, May). Application of Artificial Intelligence Based Techniques on Mentally Ill Prisoners. In 2023 International Conference on Advancement in Computation & Computer Technologies (InCACCT) (pp. 58-62). IEEE	2023
Prisoners, neural networks, prediction MH	Allahyari, E., & Moshtagh, M. (2021). Predicting mental health of prisoners by artificial neural network. BioMedicine, 11(1), 26	2021
Africa, Forensic Mental Health, Artificial Intelligence	Ogunwale, A., Smith, A., Fakorede, O., & Ogunlesi, A. O. (2024). Artificial intelligence and forensic mental health in Africa: a narrative review. *International Review of Psychiatry*, 1-11.	2024
LMIC, Artificial Intelligence	Khan, M. S., Umer, H., & Faruqe, F. (2024). Artificial intelligence for low income countries. *Humanities and Social Sciences Communications*, *11*(1), 1-13.	2024
Human-AI Collaboration, Medical Decision Making	Reverberi, C., Rigon, T., Solari, A., Hassan, C., Cherubini, P., & Cherubini, A. (2022). Experimental evidence of effective human–AI collaboration in medical decision-making. *Scientific reports*, *12*(1), 14952.	2022
Data, justice	Ramos-Maqueda, M., & Chen, D. L. (2025). The data revolution in justice. *World Development*, *186*, 106834.	2025

H. THEORETICAL REFLECTIONS

Keywords	Citation	Year
Anti-colonial, psychology	Bell, D. (2024). A Black-Archipelago Anticolonial Canon Speaks Psychology. *Review of General Psychology*, 10892680241289346.	2024
Decolonial, madness, jamaica, global mental health	Hickling, F. W. (2020). Owning our madness: Contributions of Jamaican psychiatry to decolonizing Global Mental Health. *Transcultural Psychiatry*, *57*(1), 19-31.	2020
Decolonial, global mental health	Rivera-Segarra, E., Mascayano, F., Alnasser, L., van der Ven, E., Martínez-Alés, G., Durand-Arias, S., ... & Susser, E. (2022). Global mental health research and practice: a decolonial approach. *The Lancet Psychiatry*, *9*(7), 595-600.	2022
Madness, prison, confinement, mental illness	Haney, C. (2017). "Madness" and penal confinement: Some observations on mental illness and prison pain. *Punishment & Society*, *19*(3), 310-326.	2017
Ethics, relationality, global health, Jamaica	D'souza, N. A., Guzder, J., Hickling, F., & Groleau, D. (2018). The ethics of relationality in implementation and evaluation research in global health: reflections from the Dream-A-World program in Kingston, Jamaica. *BMC medical ethics*, *19*, 29-37.	2018
Religion, mental health	Vivalya, B. M. N., Vagheni, M. M., Piripiri, A. L., & Mbeva, J. B. K. (2025). Religion and mental health seeking behaviors in war-tone zones of the Democratic Republic of the Congo. The International Journal of Psychiatry in Medicine, 00912174251316784	2025
Epistemological pluralism, RDC	Taylor, S. (2017). Making space for restoration: epistemological pluralism within mental health interventions in Kinshasa, Democratic Republic of Congo. Area, 49(3), 342-	2017
Techno-Optimism Africa	Platzky Miller, J., Sander, A., & Srinivasan, S. (2022). Control, Extract, Legitimate: COVID-19 and Digital Techno-opportunism across Africa. Development and Change, 53(6), 1283-1307.	2022
Data, Justice, Revolution	Ramos-Maqueda, M., & Chen, D. L. (2025). The data revolution in justice. *World Development*, *186*, 106834.	2025
Critique, global mental health	Lovell AM, Read UM, Lang C. Genealogies and Anthropologies of Global Mental Health. Cult Med Psychiatry. 2019 Dec;43(4):519-547. doi: 10.1007/s11013-019-09660-7. PMID: 31729686.	2019
MHGap, Interviews with writers of guidelines, universality	Mills C. Strategic universality in the making of global guidelines for mental health. Transcult Psychiatry. 2023 Jun;60(3):591-601. doi: 10.1177/13634615211068605. Epub 2022 Jan 19. PMID: 35043746; PMCID: PMC10486146.	2023

This page is intentionally left blank.



Coupe AA

MALEMBE, MALEMBE?
TECHNOLOGY FOR MENTAL HEALTH IN DETENTION
Jonathan Luke Austin

HUD WORKING PAPER
Copenhagen | Geneva | 2025

UNIVERSITY OF COPENHAGEN · EPFL · HEAD Genève · Geneva Graduate Institute · Fonds national suisse