IN ASSOCATION WITH
THE INTERNATIONAL CENTER FOR ATTITUDINAL HEALING

MENTAL HEALTH CARE FOR YOUTH IN INDIA:

CURRENT POLICY AND RECOMMENDATIONS

Ashoka's **Changemakers**

APRIL 2008

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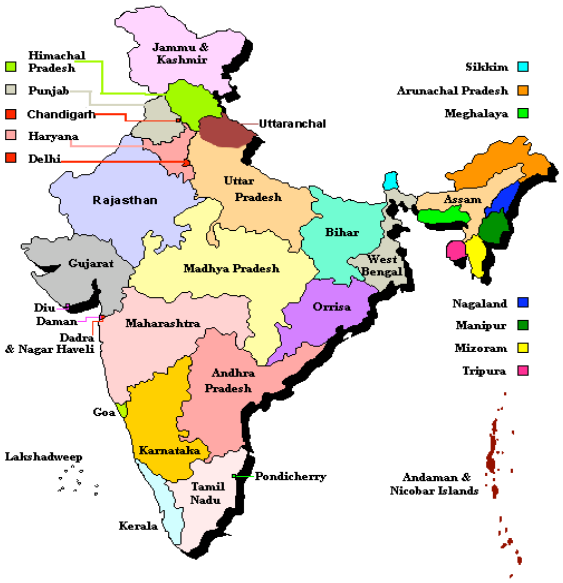

Source: Where In City

CULTURAL AND HISTORICAL CONTEXT

With just over 1 billion people, India is the second most populous country in the world. Over 80 percent of the population is Hindu, followed by Muslims (13.4%), Christians (2.3%), Sikhs (1.9%), and Buddhists (0.8%).[i] Geographically, India consists of 28 states formed on a linguistic basis, whose boundaries have remained largely unchanged since the States Reorganisation Act of 1956.

A myth-based society

Because India is a myth-based society, it is important for mental health and psychosocial professionals to distinguish between tradition and superstition in the provision of mental health care. Indeed, the practice of psychological services "…only emerged in the British era…[with] generations of psychiatrists [who] have been groomed on British and Western textbooks."[ii] As a result democratic India is experiencing difficulty incorporating such services—which are often associated with colonization—both into the national health care system, and into the minds of the Indian people.

The first step is to find a diagnostic framework for mental disorders in a culture that possesses nuanced interpretations of emotional states. Globally, mental health professionals refer to a text called, the "Diagnostic and Statistical Manual of Mental Disorders" to diagnose psychosocial problems, such as depression. However, in India (and many Asian cultures), this text is rendered irrelevant by religious and philosophical beliefs.

As an example of this phenomenon, Dr R. Raguram of the National Institute of Mental Health and Neurosciences indicated that Indian patients were as comfortable describing somatic pains (aches, illness, etc.) as they were describing their feelings, and thus did not believe they were experiencing depression as defined by Western medicine.

> "We came across so many different methods of expression of sadness…it was not just sadness but various shades of meaning ascribed to sadness. For example, *dukha* is not just sadness, it's a kind

> of spiritual suffering that you are in because it is preordained. You're expected to go through this suffering for salvation, to further yourself in this world. And *dukha* has no negative connotation. The other common word is *bejari*…*Bejari* means a little sadness tinged with boredom. So there seems to be a richness of vocabulary to articulate inner states of feeling."[iii]

The richness of vocabulary, none of which alludes to medical issues, hinders diagnosis of mental illness as it is commonly defined.

Additionally, the well-known concept of *karma*— the system of societal debts and credits connected with rebirth—can be another obstacle to finding a diagnostic framework. *Karma* can confuse those who subscribe to Hindu philosophical works. Take for example, the case of suicide. On the one hand the Gita and the Upanishads decry suicide because one cannot realistically escape from the cycle of birth and death by committing it, since one's current and past actions will manifest in reincarnated life. However, some of the greatest emperors and heroes in Indian mythology have committed suicide, and in some cases, one is allowed [even encouraged] to go on Mahaprasthana, or "a while in the northeasterly direction with sustenance," once one's worldly duties have been completed.[iv] The mixed messages can cause confusion about acts that are mythically honorable, and ones that warrant mental rehabilitation.

Indians at large do not wholly resign their fate to karmic powers, but there is a need nevertheless to address *karma* as a connective tissue between past deeds and current suffering. With a burgeoning population, efforts must be made to address these deep-seated belief systems in order to efficiently and effectively disseminate psychosocial services and establish community-based care.

TRAUMA AND SOCIAL ISSUES

> "We have a growing population with depression because of loneliness, lack of meaning, connectivity, and unemployment. We have a large number of people on the brink of suicide. We are seeing the age of onset of mental illnesses going down very rapidly. It's going to become a very big problem in India."[v] —Dr. Harish Shetty, Co-organizer of Maitri, A Project for Families of the Mentally Ill

32 percent of the population in India is under the age of 15 years; many of those suffer chronic mental disorders due to population growth, and issues of trauma. An Indian study reported that suicide accounted for a staggering quarter of deaths in boys and between half and three-quarters of deaths in girls aged 10–19 years.[vi] Resources must be devoted to children and youth in India in reconciling with trauma endured by this target group in the following categories:

Caste violence

According to 1999 study conducted by Human Rights Watch, more than one-sixth of India's population, some 160 million people, live a precarious existence, shunned by much of society because of their rank as “untouchables” or Dalits at the bottom of India's caste system. Although the caste system was abolished as part of the Indian Constitution drafted in 1950, this "hidden apartheid" still takes place today. Dalits often live in extreme poverty, are denied land, disenfranchised, and generally treated as second-class citizens. Dalit children are frequently made to sit in the back of classrooms, and more strikingly, make up the majority of those sold into bondage to pay off debts to upper-caste creditors. Among Dalits there are high rates of depression and drug abuse (particularly brown sugar/heroin), and rapid spread of HIV.

Bonded slavery and child prostitution

An estimated forty million people in India, among them fifteen million children, are bonded laborers.[vii] Bonded labor is a form of slavery in which landless families take loans from landowners and moneylenders. In return they commit themselves and their children to work, often for no pay, for an indefinite amount of time. In this area, people are held in this form of slavery against loans of as little as Rs.1,000 ($23).

In India's southern states, thousands of girls are forced into prostitution before reaching the age of puberty. Devadasis, literally meaning "female servant of god," usually belong to the Dalit community. Once dedicated to this service, the girl is unable to marry, forced to become a prostitute for upper-caste community members, and eventually auctioned off to an urban brothel.[viii]

Forced marriage

In India, more than 50 percent of girls marry before age 18 or without giving their consent. Transgressions of these norms can result in vicious attacks, such as disfiguring acid attacks, intended to destroy the woman's life and send warnings to others.[ix] Many young women are kept at home in purdah (home confinement), and when they are married off, are forced to live with the unknown family of their husband. According to Elizabeth Visceglia, a psychiatrist working near Varanasi in northern India, "Depending on how rural the area, very young girls (aged seven to 11) are not infrequently married off, and I know that suicide among these girls is at a high rate."[x]

HIV/AIDS

Over 2.5 million youth in India under the age of 25 are living with HIV/AIDS.[xi] India has made great strides towards curbing the rise of infection through national awareness and youth ambassador programs, but South Asia is only second behind Africa in its volume of the infection. Intravenous drug use and the prevalence of a sex trade have fueled the epidemic.

Tsunami and disaster relief

Many children and youth experienced separation from or loss of family members in the Tamil Nadu, Andaman, and Nicobar regions of India after the tsunami in December 2004. In Tamil Nadu alone, 480 children lost *both* parents to the tsunami and its immediate affect effects.[xii] Other children displayed acute fears of rushing water, as well as airplanes flying overhead as the engine sounds reminded them of the ocean. While emergency medical care was provided to these regions, and the children placed in orphanages or with other family members, the long-term psychological consequences of parental loss and the tsunami deserve proper attention.

CURRENT STATE OF MENTAL HEALTH CARE

Domestic policy

For a country as large as India, the mental health resources are scarce, especially in the rural regions. According to the WHO, the proportion of the country's total health budget to GDP is 5.1 percent, only .83 percent of which is allocated to mental health.[xiii] There are only 3 psychiatrists per one million people in India, and very few are based in rural areas.[xiv]

In 2002, the 10th Five-Year Plan of India emphasized some strategies for the National Mental Health Programme, but apportioning resources to the various states has been problematic. Most of the money allocated to the program was dedicated to modernizing medical facilities, strengthening psychiatric higher education programs, and improving advocacy, education and research.

To be sure, the Indian health ministry recognizes the importance of developing community based psychosocial programs. Indeed, the 10th Five-Year Plan includes an initiative, "…to shift the focus from the present custodial model to a community-based approach with extension of basic mental health care through outreach facilities."[xv] This included the extension of district mental health programs to 100 districts (from a mere 22). The current figure for districts with mental health programs in the mid-60s.

Foreign Aid

The US government funds mental health in India primarily through USAID's South Asia Regional Initiative for Equity (SARI/Equity). Many of the mental health issues that USAID focuses on are generally a result of trauma, most specifically related to the tsunami. However, they have also made a large effort to provide mental health care to human trafficking survivors. Also, in 2007, USAID put forward a massive project to train thousands of community-based mental health workers in India. This project was part of a larger Human Resources for Health (HRH) capacity building initiative that India has recently taken on with the help of the US government, specifically USAID.

USAID provided $14 million dollars in funds to recovery efforts in India through September 2007. Part of this $14M went to training 2,000 community level mental health workers. USAID reports that roughly 9,000 families were counseled because of these efforts. In specific regard to mental health care, USAID partnered with CARE, Project Concern International (they provide counseling specifically to children who are seeking trauma care), ACTED, and the UNDP.

USAID often partners with UNIFEM, the Academy for Educational Development (AED), and the UNDP for such mental health-related projects. The UNDP also initiated psycho-social relief programs with India's Ministry of Health and they have proven effective.

NGOS and other funding streams

Private development dollars, for the most part, come from US-based NGOs raising money and providing resources to partner groups in these areas. This is especially the case in India. For example, organizations such as CARE, World Vision, and Catholic Relief Services play a pretty strong role in providing these services in India. Also, Project Concern International works closely with USAID and Indian communities to provide youth counseling and mental health care for trauma survivors. Baxter International Foundation funds mental health initiatives to both the

Nagaoattinam District in India, and Free the Slaves works with two of the nonprofits listed in the report prepared for the International Center for Attitudinal Healing.

For more NGOS, see appendix.

RECOMMENDATIONS

The need for mental health care suggests an opportunity for CAH to provide direct psychosocial services that are culturally accepted, and can be distributed through existing networks/systems of care. Employing a peer counseling method will serve as an practical compromise between accepted systems of traditional healing and effective systems of psychosocial methods.

(1) CAH must **facilitate the development of self-managed, locally sustainable systems of care, involving a diverse set of stakeholders who have direct interaction with the target group of children and youth.** From government-funded schools to individual family units, psychosocial services must be introduced into community and pedagogical networks in order to create sustainability and foster widespread acceptance of mental health issues.

While India has specific programs in place for disaster-affected populations, it is crucial to introduce or continue programs that address other issues of trauma using the successful disaster-related model:

> "In resource-poor settings with few trained mental health professionals, community workers were taught basic mental health interventions by teams of psychiatrists, nurses, and social workers. This train-the-trainer, community-based approach has implications for natural and man-made disasters in developed and developing countries."[xvi]

The "Train the Trainer" program, widely touted in analysis of the international response to the tsunami, has resonance with the peer-oriented training in development with CAH.

(2) **Make efforts to understand historical, cultural and religious context to increase buy-in from civilians and remove stigma.** Hindu philosophies, traditional healers and other cultural beliefs deeply embedded in the culture can effect a patient's willingness to partake in psychosocial activities, and efforts made to understand that will aid in the expedient and effective delivery of psychosocial care.

> "We have to go beyond surface representations of illness, and examine local understandings. You can diagnose according to a universalistic framework, but your interventions have to be contextualized. You have to listen closely to patients, families and their own personal beliefs and tailor the treatment. Otherwise psychiatry will have an alienating effect in developing countries."[xvii]

To be sure, aid organizations wishing to better understand this context and prevent alienation from target populations should also look to studies conducted on the effectiveness of traditional healing centers. In one such case, researchers from the National Institute of Mental Health and Neurosciences examined the effect of a cost-free short-term stay at a 60-year-old temple said to have healing powers.

Of 31 patients initially diagnosed with paranoid schizophrenia, bipolar and delusional disorders, Dr. R. Raguram of the National Institute of Mental Health and Neurosciences and his team published in the *British Medical Journal* that the mental health ratings of the patients improved by up to 20 percent.[xviii] This marriage of superstitious beliefs with the familiar, supportive

environment of the temple is worth noting as an effective method of healing and mental rehabilitation.

These services were also offered at an affordable rate or cost-free, which, according to the lead researcher on the study, greatly affects participation and effectiveness:

> "For mental healthcare, even in developed countries, the bottom line is affordability of care. And it's also about the de-stigmatization of mental illness. So a person who's chronically mentally ill might be much more at ease seeking free care from a source which is in congruence with their own belief systems."[xix]

Thus, efforts must be made to find more such networks and locally accepted customs and centers through which CAH may offer peer counseling and other psychosocial services.

(3) CAH must **employ peer counseling methods and implement outreach programs in partnership with organizations that offer *long-term* continuum services** to youth who have suffered from trauma**.** Again, integral to this strategy is the involvement of a diversity of stakeholders, especially those who interact directly with the target group. As in Rwanda, professionals and aid programs that come and go quickly after a traumatic event can be harmful to the effects of mental health care, and may work to the detriment of long-term recovery.

> "…the daily scene in an Indian courtroom, where lawyers repeatedly would ask a child to narrate violent instances such as sexual assault, not realizing the damaging effect such a legal methodology would have on a child."[xx]

Even if legal justice is brought to bear for against perpetrators of trauma, there is a notable absence of follow-up services once a trauma victim is returned to family and peer groups. Children and youth who are rescued from bonded labor and slavery experience the same phenomenon. Ultimately, the most effective programs for victims of trauma provide immediate medical and education services, but also comprehensively address mental rehabilitation and reintegration into society.

CONCLUSION

In a nation as large and populous as India, the social issues that may affect children and youth are numerous and widespread. What remains constant are the ways in which mental health and well-being must be addressed across socioeconomic barriers and psychosocial services tailored to a diversity of traumatic experiences.

> "The nervous system is inscribed with our history of socialization and cultural learning…There are human problems that are constituted by our way of life, and solutions can be found not in the physiology of the brain, but in the way of life, values, and commitments that people choose as they navigate a world that is socially constructed in a very literal sense."[xxi]

APPENDIX I: PARTNERS

DDWS (Bal Vikas Ashram) Bal Vikas Ashram is a rehabilitation center for children aged 8-14 who have been rescued from slavery in Uttar Pradesh, in northern India. When the Ashram staff take children [who have been nursed back to health] back to their home villages, they work with the parents to obtain government self-employment funds and other entitlements: often owning a few goats or a sewing machine can protect a family from bonded labor in the future. As well as literacy and knowledge of their rights as citizens, graduates of the Ashram bring back vital ideas to their villages, such as how to organize microcredit groups, how to operate a bank account, techniques for plant protection and dry land farming, and how to use solar energy.

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MSEMVS (Society for Human Development and Women's Empowerment) focuses on empowering groups of local parents to remove their children from slavery and send them to MSEMVS transitional schools.

MSEMVS uses a three-pronged approach, enrolling children in transitional schools (50 children per school, usually staffed by two teachers and 1 community worker). The children have a large hand in running the school, forming cleanliness committees, recreation committees, vigilance committees, etc. Secondly, mothers join Self-Help groups with the aim of finding alternative sources of income and confidence in gaining economic independence. Finally, MSEMVS forms its own community vigilance groups to monitor for signs of exploitation.

New Light New Light is a small initiative funded by the Shadhika Foundation whose mission is to promote gender equality through education and life-skill training, thereby reduce harm caused by violence and abuse to women and young children. Programs include shelter, legal advocacy, education and practical life-skills training.

Khaligat is a notorious quarter in Calcutta. It is one of the poorest neighborhoods of the City. Mother Teresa's original Hospice for the Dying is in this quarter, as is one of the busiest red light districts in India. Urmi Basu, a trained social worker and dedicated women's advocate, has become concerned with the plight of the large population of sex workers in Khaligat. These women live in unimaginably crowded slum conditions and ply their trade with their children often watching. As a rule, their daughters follow in their footsteps once they reach age 14 or 15.

Using three available rooms in an old temple, and without any funding, Urmi started an evening creche/nursery school/youth program last year, designed to insulate some of the children from their mothers' work environment. Operating during prime "working hours", from 6 pm to 10 pm, the New Light Creche provides a safe haven to over 30 children, including some babies and toddlers. The older children receive school instruction from volunteer teachers.

162 Kalighat Road
Kolkata 700 026
West Bengal, India
telephone: (91 33) 2485-0068
mobile: (91) 98311 23976
fax: (91 33) 2870-0234
email: newlight@india.com

The Richmond Fellowship Society The Richmond Fellowship is a U.K.-based organization that runs out of Bangalore, and offers primary care services to mentally ill patients as well as a Masters program for those wishing to achieve a degree in psychosocial rehabilitation.

"Asha" Halfway home
501, 47th Cross, 9th Main,
V Block Jayanagar,
Bangalore-560 041
Phone: (080) 26645583
Fax: (080) 26341673
Email: rfsindia@vsnl.com

"Chetana" Day care centre
40-1/4, 6th Cross,
Vajpeyam Gardens, Ashoknagar, Banashankari I Stage,
Bangalore - 560 050
Phone: (080) 26676134

RF P.G College for PSR
40-1/4, 6th Cross,
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Ashoknagar, Banashankari I Stage,
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Phone: (080) 26676134
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Sangath Foundation Sangath is a well-established NGO in the Goa region of India, working specifically on the developmental and educational needs of children and youth. Their programs include research and development, primary care services, as well as community-based initiatives funded by international NGOS. Programs include training of staff in provision of care and education, with one program specifically dedicated to mental health issues during the HIV/AIDS crisis.

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Shadhika Foundation Shadhika is a non-profit, secular, apolitical US foundation. Our mission is to assist needy women and children in India by funding select non-profit initiatives there. Working with local agencies in India, Shadhika focuses on "grass roots" organizations with quality, integrity and strong, dedicated leadership. Often it provides "early stage" funding as well as operational and strategic advice. We help the agencies get established and become eligible for more significant funding from other sources. We also personally visit all projects and encourage collaboration between them.

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Udayan Care is a nonprofit organization, largely centered in NCR (National Capital Region) but also in Haryana, Uttar Pradesh, West Bengal and Tamil Nadu. It is committed to sustainable social development through working with the disadvantaged children and women. It devotes resources to three different programs: L.I.F.E (Living In Family Environment) HOMES for children, who are abandoned or orphaned and do not have natural Families; vocational training and personality development programs for young girls; a structured system for volunteers to contribute to the development of Udayan Care as well as the community.

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APPENDIX II: ASHOKA FELLOWS

The following Ashoka fellows have completed or are currently innovating work in India related to mental health care and community-based healing. Their association with Ashoka may prove valuable to CAH in establishing networks and contacts on a grassroots level in the Indian region.

* **Nirmala Srinivisan** (India, 2003, Ashoka Fellow): Through her organization AMEND (Association for the Mentally Disabled), Srinivisan is creating self-help networks to equip the mentally ill, their families, and caregivers with the information, training, and support necessary for them to play a proactive role. Learning from her own experience how the social stigma surrounding mental illness creates tremendous emotional strain on families, AMEND organizes a family support group for people with psychiatric illness. Srinivisan has also spearheaded mental health advocacy on the national and local level.

* **Anuja Gupta** (India, 2002, Ashoka Fellow): Gupta identifies female survivors of sexual abuse through colleges networks, ladies' & corporate wives' clubs, and establishes support groups—a safe and confidential space for women to share their experiences and feelings with knowledgeable, concerned individuals. For new members of her group, she provides educational groups based on information exchange and discussion. In turn, this prevents further sexual abuse by raising awareness through family networks.

* **Sohini Chakraborty** (India, 2003, Ashoka Fellow): Through self-choreographed performances and presentations made at seminars, workshops, and media events, sexual trauma survivors are able to reintegrate, and gain maturity and confidence to become peer educators themselves. Chakraborty strategically used high-profile conferences on HIV/AIDS to highlight the achievements of Sanved. Sanved also performs at cultural events where tickets are sold commercially. Since early 2002, Chakraborty has run a school program that facilitates interaction between mainstream school students and the child victims of sexual violence. She has started with five schools in which there are regular sessions every three months to bridge the gap between the children, to help them understand and respect each other.

* **Kedar Ranjan Banerjee** (India, 1990, Ashoka Fellow): Banerjee, alerted by the results of a door-to-door detection campaign by his National Institute of Behavioral Sciences, identified high-risk urban youth and established "detoxification camps," Medical Aid camps, and outdoor clinics aimed at the reduction of drug use and mental health issues.

APPENDIX III: CONFLICT RESOLUTION AND LIFE SKILL MANAGEMENT REPORT/NGOS

Life skills management programs appear to be a component of social programs predominantly for children who have been victims of forced labor and those who have been living in poverty. The Smile Foundation coordinates and funds a number of local NGOs, school programs and "training of trainer programs" throughout the country, working to educate and provide vocational and life skills training to women, youth, and at-risk/vulnerable groups. Their website is rich with information about partnering with local organizations and different models for education and community-based care.

It should be noted that life skills management is often combined with a foundation program areas that address general primary and secondary education needs. Pratham, a global NGO with a focus on literacy in India, was recently (June 2007) granted $9 million by the Hewlett and Gates Foundations to support their "Read India" campaign. Part of the grant will also support, "a rigorous evaluation of the Read India program, the large-scale expansion of a model to rapidly improve learning levels of children in language, mathematics, physical sciences, social sciences and life skills, and an evaluation of individual learning outcomes."[xxii]

There are fewer contexts in which conflict resolution is an explicit piece of educational initiatives in Indian regions, as the country has not recently been through a period of armed conflict (as with Rwanda). One area that may suggest an opportunity for conflict resolution peer counseling is in communities that still suffer a vast stratification between the "untouchable"/dalit children and their peers.

Below follows a short list of independent organizations working in India in the areas of conflict resolution and life skills management.

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Smile Foundation India The Smile Foundation partners with local organizations in over 20 Indian states to provide health and educational resources to at-risk youth and street/slum children in the poorest areas. Their list of projects is extensive, and the initiatives implemented through local, school, and community-based networks.

In one example of a educational program that includes a life skills and conflict resolution focus, Smile Foundation and Child Survival India [CSI] came together for a project named Nanhe Sapne (Little Dreams) in the most vulnerable areas of Delhi, the capital of India. The project provides care and support of HIV inflicted, affected and vulnerable children. The focus is on children inflicted with HIV, children of HIV inflicted parents, but of note, also addresses vulnerable children living on streets, and those who have been victims of child labor.

Among the relevant services provided by this project: supportive care (counseling, emotional support, providing education, health, nutritional therapy, gainful engagements etc.); life skills sessions on peer pressures, conflict resolution, sexual abuse, HIV/ AIDS etc for working /street children (adolescents); and a special focus on making the program self sustainable in the communities and localities where it has been put into place.

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Udayan Care is a nonprofit organization, largely centered in NCR (National Capital Region) but also in Haryana, Uttar Pradesh, West Bengal and Tamil Nadu. It is committed to sustainable social development through working with the disadvantaged children and women. It devotes resources to three different programs: L.I.F.E (Living In Family Environment) HOMES for children, who are abandoned or orphaned and do not have natural Families; vocational training and personality development programs for young girls; a structured system for volunteers to contribute to the development of Udayan Care as well as the community. Udayan also staffs a Health Education and Life Skills program through the school system in which they address, among other issues, life skills management and conflict resolution.

Udayan Care was listed in the original India country report as having high partner potential for CAH.

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Beyond Borders Beyond Borders is a very interesting, voluntary, youth-led (ages 17–25), youth-run initiative supported by the British Council and active in Sri Lanka, India, Bangladesh and (formerly) in Pakistan & the UK. Beyond Borders provides a [predominantly online] space for young people to actively express themselves and take action on development issues affecting them. Currently the group is working on issues related to peace, governance, citizenship and sustainable development.

Beyond Borders was started by the British Council as a learning and networking project in 2004 in Pakistan, India, Bangladesh, Sri Lanka and the UK. in each of these countries core groups made up of young people engaged in action projects based on the themes of Identity, Diversity and Active Global Citizenship

One of their "action projects" includes life skills training. Beyond Borders' workshops aim to work at three levels: individual growth (aimed at conflict resolution, confidence building and various other methods of personal growth and introspection), growth of the group (sessions such as team and trust building which help in getting the group together), placing the group in the larger context of the world around them (by discussions and various tools like theatre, the group is sensitized to the issues around them such as environment and sustainable development).

The group also helps local children formulate an action project on any issue they feel strongly about. The group has successfully facilitated workshops with Arya Orphanage, Daryaganj and Jamghat, a street children's shelter, and has been conducting workshops on life skills with members of the British Council children's library in an attempt towards raising funds for their project.

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BB India

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swatichawla@gmail.com

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