The relationship between reproductive health and mental health is a topic which is ill understood and even less put into practice. Mental health has always been the Cinderella of health concerns in developing countries, even though health policy and social components nearly 30 years ago. Can we really afford to be mentally well when our bodies are sick and our stomachs empty? Isn't mental illness largely due to consumerism and materialism? These are just some of the cliches and challenges one faces in a discussion on mental health.

How does mental illness relate to Reproductive Health? As this booklet will demonstrate there are numerous close linkages between these apparently different health domains. Just like Reproductive Health, women's mental health cannot be considered in isolation from social, political and economic issues. When women's position in society is examined, it is clear that there are sufficient causes in current social arrangements to lead to common mental health problems. Gender dynamics and power relations that lead to an unequal status for women in a variety of situations are likely to make their lives more stressful. Indeed, "It is not surprising that the health of so many women is compromised from time to time. Rather, what is more surprising is that stress-related health problems do not affect more women" (see Dennerstein et al, 1993). For many years, Indian psychiatry has paid special attention to the medical and biological linkages between reproduction and mental illness. For example, one study links the menstrual cycle with hospital admissions. Epidemiologists have explained away the greater reported mental distress in women by saying that it had to do with their 'hormones' and changes associated with menopause. Such easy explanations however need to be questioned. What has been left out of such accounts are the social shaping of reproductive experiences and how that affects their mental health. This section of the Reproductive Health Resource Pack briefly tries to understand Mental Health, its linkages with Reproductive Health, current issues and debates pertaining to programmes and policy relevant to women's issues and recommendations for future action and research.

Understanding Mental Health and Mental Illness

What are mental health and mental illness

In Indian languages the word 'manasik' is usually translated into English as 'mental'. It originates from the word 'man' which includes both emotional and intellectual capacities. However, the English word 'mental' refers to the latter and may neglect or occlude the emotional aspect. This is not just a linguistic issue because the work 'mental' has a stigma attached to it in India due to its association with colonial institutions such as mental asylums and inhuman treatment. When women suffer these disorders, they are likely to suffer far greater discrimination and stigma in the areas of life such as marriage and employment than men. The very diverse conditions of infantile autism and hyperactivity, depression and schizophrenia, alcohol and drug abuse, Alzheimer's disease and mental retardation all fall under the broad umbrella of mental illness. Schizophrenic disorders, which are the predominant conditions in psychiatric hospitals and clinics in developing countries, are rare in a community setting.

In the Indian context, the mental health of women has emerged as an important agenda on women's health and rights related work in recent times. Women activists see women's mental health as a result of women's inequality and political relationships. Women's mental health status is influenced by the social institutions and other cultural and political structures which have a direct bearing on women's day-to-day lives and this plays an important role in the mental well being of women.

Mental health has been defined as *the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well being, the optimal development and use of mental abilities (cognitive, affective and relational), the achievement of individual goals consistent with justice and the attainment of preservation of conditions of fundamental equality.*[1]

Mental illness could include behavioral disturbances such as violence, agitation and being sexually inappropriate. It can affect a person's ability to perform normal day-to-day activities at home and at work. Unfortunately people with mental illness, particularly women are often discriminated by the community and also by their families.

The recent Global Burden of Disease (World Bank/WHO 1996) report listed the most important causes of disability (as measured by disability Adjusted Life Years, a measure of the number of years of life lost by disability due to a specific illness). To the surprise of many public health experts, five of the top 10 causes of disability were mental disorders: depression, alcohol abuse, schizophrenia, bipolar disorder (also referred to as manic-depressive

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[1] Dennerstien L, Astbury J, More C. *Psychosocial and mental health aspect's of women's health.* Geneva: WHO; 1993.

disorder), and obsessive-compulsive disorder. Depression was the single most disabling disorder, accounting for more than one in ten years of life lived with disability.

Types of Mental Illness

There are number of different types of mental illness. Mental illness can produce severe disability and sometimes can lead to death. The commonest types of mental illness in the community or general health care settings are the common mental disorders and disorders related to alcohol dependence. Mental illness could be broadly classified into six categories.

(i) Common Mental Disorders (CMD)
CMD consists of two types of emotional problems: **depression and anxiety**. Depression means feeling low, sad, fed up or miserable. It is an emotion that almost everyone suffers from at sometime in his or her life. To some extent it can be thought of as 'normal'. But there are times when depression starts to interfere with life and then it becomes a problem. In the case of antenatal and postnatal depression, the interaction of psychosocial factors with hormonal factors appears to result in an elevated risk. For example, marital disharmony, inadequate social support and poor financial situation are associated with an increased risk of postnatal depression. A large number of studies provide strong evidence that gender based differences contribute significantly to the higher prevalence of depression and anxiety disorders in girls and women when compared to boys and men. The feeling of a lack of autonomy and control over one's life is known to be associated with depression. The gendered roles and responsibilities in the society leave women with little control over important decisions concerning their lives.

Studies from South Asia reveal that up to 40% of adults visiting primary care centers suffer from a CMD. Both community-based studies and studies of treatment seekers indicate that women are disproportionately affected by CMD. A recent collation of five studies from four low and middle-income countries found that women were two to three times more likely to suffer CMD than men.[2] There are effective, and relatively cheap, treatments for CMD: yet, the vast majority of patients in India do not have access to these and are, instead, given sleeping pills and other symptomatic medications and subjected to numerous investigations and tests.

(ii) Bad Habits (Alcohol and drug dependence)
Other mental illnesses that are common in the community are habit problems such as alcohol and drug abuse. At present, evidence suggests that these

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[2] see Patel et al, 1999

problems are relatively uncommon in women in India. A person is said to be dependent on alcohol or drugs when their use harms the person's physical, mental or social health. Typically it becomes difficult for people to stop using these substances because they may develop physical comfort and an extreme desire to consume the substance (withdrawal syndrome). Dependence problems cause great damage to sufferers, their families and ultimately to the community. Alcohol, for example not only harms the drinker through its physical effects but it is also associated with high suicide rates, marriage problems and domestic violence, road traffic accidents and increased poverty.

(iii) Severe Mental Disorders
This consists of schizophrenia, manic depression disorder (bipolar disorder) and brief psychoses. Although the prevalence of chronic psychotic illnesses such as schizophrenia and bipolar disorders in women may be less than that of depression, anxiety and related conditions, they pose an immense problem in management and rehabilitation. Their propensity to be chronic, sometimes unresponsive to treatment, the resultant disability in various aspects of functioning, and above all, the stigma attached to these illnesses and the social sequel make it a public health issue, notwithstanding the smaller numbers. While men and women are equally affected by schizophrenia, there have been some differences in their manifestations and course and outcome. A consistent finding has been a higher mean age at onset and first hospitalization for women suffering from schizophrenia.

(iv) Mental Retardation
Mental retardation is a condition, which is present from birth or early infancy and is associated with delayed development of the child's intellectual abilities. Mental retardation is not a mental illness in the strict sense of the term. It is a state or a condition that is present from very early childhood and remains present for the rest of the person's life. There can be various degrees of mental retardation ranging from mild, moderate and severe retardation.

(v) Mental Health Problems in the Elderly
The elderly suffer from two main types of mental illness – depression and dementia. Depression is often associated with loneliness, physical ill health, disability and poverty. Dementia mainly affects older people mostly above the age group of 65 yrs. It is a disease where the brain gradually degenerates and the patient starts to loose the memory.

(vi) Mental Retardation in Children
Certain types of mental illness which are common with children are dyslexia which affects the learning abilities of a child and affects the mental growth, hyperactivity, conduct disorders, depression and bed wetting.

Society, women and mental health

Studies in the area of physical health show how the organisation of health care in the country has been designed to privilege a certain class at the expense of others depending upon the socio-economic status and the function of individual is a society. It is well documented that women in particular,

have been the enduring victims of this political organisation of health care. Statistics on the prevalence of mental illness in the community show that women are more frequently ill than men. In general, the utility of mental heat services is not commensurate with the prevalence (see Bhargavi Davar, 1999). In India the proportion of women attending the facilities is very low, as compared to men. This low attendance is partly explained by the non-availability of resources for women. The traditional mental health services appear to primarily cater to the needs of male patients. Research indicates that mental hospitals show gender -discrimination in terms of availability of beds. In short, even though women are more frequently ill in the community, their utilisation of mental health services is lower than men. This discrimination is also visible in the access to mental health care of mentally handicapped children. Besides this, parents of handicapped young girls are less motivated to send them to these institutions for rehabilitation. There are no economic gains in doing this, as there might be in the case of boys who can still be trained for some useful employment. The mentally handicapped girl also helps out with the household chores. As she is unlikely to get married, parents would think it a waste to expend resources, material or psychological, on her.

Mentally ill people, in general, are forced to suffer a stigma in addition to their psychological suffering. Social attitudes towards and understanding of mental illnesses in women are much more pernicious than that towards men. A mentally ill man is an economic burden, but a mentally ill woman is an economic as well as a moral burden. Mentally ill women may be severely condemned for any behavior that could be perceived as a violation of feminine nature and modesty, such as tearing off clothes, violence towards others, lack of attention towards the preparation or consumption of food, neglect of children, etc. Mental illness in women is seen as a moral disgrace to the family and thus censure, neglect, rejection and isolation are commonly associated with mental health. In the case of men it is a cause for sorrow, not disgrace. Many mentally ill women receive no social support, either from their family not into the family into which they get married. Married and mentally ill women are more likely to be sent back to their natal homes, abandoned, deserted or divorced. Our social way of life, its hierarchies, gender relations and social structure, other than out perception of mental illness, all contribute towards the large-scale neglect of mental illness in women.

Factors behind the higher prevalence of mental illness in women

Recent studies from India has shown that the prevalence of mental health problems is more in women than in men for common mental disorders as well severe mental disorders. According to an analysis made in another study

of mentally ill women in India, women are entrusted with contradictory roles which is an important reason for their mental health problems. In their nurturing and care giving roles as mothers and wives women are supposed to be in charge. However the image of women is weak and she is in subordinate roles in the family. This constant change in roles and from one of strength to one of passivity leads to enormous pressures and mental health problems. Mental disorders have also been shown to be linked to poverty, powerlessness and alienation and these conditions affect women disproportionately more than men due to the gendered roles and expectations. Some of the other reasons why women are more vulnerable to mental ill-health are as follows:

➢ Women face greater stress – this is not only related multiple roles that women play but they are also exposed to gender based violence
➢ Women's inability to fulfill reproductive roles – eg. not produce a male offspring, or to be childless, brings on a circle of abuse and violence which has been shown linked to suicide as well.
➢ Fewer educational and economic opportunities
➢ Women and men are treated differently once they are mentally ill. While women (wife, mother) care for men who are ill, women who are ill are either not married or sent back to their natal families.
➢ Women with symptoms of mental illness are taken less seriously and are less likely to receive appropriate care

In addition to the above a common explanation of the greater prevalence of mental illness in women is the hormonal changes occurring during different stages of the reproductive cycle. Although genetic and biological factors play some role in the higher prevalence of depressive and anxiety disorders among women, their extent and manifestations may be mediated by the socio-cultural settings in which women live. Clinical entities include pre-menstrual syndrome, pre-natal depression, post natal depression, post natal psychoses and menopausal syndrome. Women may experience depression during the pregnancy or after childbirth, in the post- partum period (postnatal or postpartum depression).

Possession

Witch hunts are regularly reported in India. Women who are possessed are usually described as ugly, having supernatural powers, strong-willed, cruel, cannibalistic, and sexually deprived. Possession and trancing are of interest to psychology, because it is a peculiar type of human behavior, common enough, but yet somehow not 'normal'. In possession and trancing behavior, there is the deviance of the person from her 'usual' behavior. Women in general, but especially teenage girls or girls reaching menarche, married women, pregnant women and new mothers are said to be vulnerable to possession by spirits.

Possession, trancing and MPD (Multiple Personality Disorder) are related and involve a splitting of consciousness by a process called dissociation. In dissociation, for example, following childhood sexual abuse, memory links of the traumatic episodes are severed and form a parallel line of memory which is then disowned as not belonging to oneself. Complex relationships between these parallel memories, each disconnected with the rest, results in the dissociative behaviors of trancing, possession as well as MPD.

From the discussions available in a number of anthroplogical sources, it is evident that the culture-specific phenomena such as trancing and possession are shaped by gender. Why is it that it is always women who are more frequently possessed, tranced or become hysterical? It is not possible to answer this question without situating it squarely within the politics between the sexes within cultures and the distribution of power.

Linkages between Reproductive Health and Mental Health

How does mental illness relate to Reproductive health? As this booklet will demonstrate there are numerous close linkages between these apparently different domains. Just like Reproductive Health, women's mental health cannot be considered in isolation from social, political and economic issues. The areas of intersection of reproductive and mental health are considerable in scope and include, for example psychological issues related to childbirth, violence, rape, adverse maternal outcomes such as stillbirths and abortions, reproductive tract surgeries, sterilization, premarital pregnancies in adolescents, HIV/AIDS and the impact of caring, menopause and infertility. In this resource pack, all of the above cannot be dealt due to the vastness but this will provide an overview of some key areas of intersection, focusing on the commonest mental disorders.

➢ **Reproductive Symptoms and Psychological Disorders:** Weakness and tiredness are some of the most common symptoms reported by women in community and primary care populations. Weakness is almost always taken to be caused by anemia. However, weakness is also a hallmark symptom of depression. A number of recent studies have demonstrated that many women with complaints such as weakness and white vaginal

Comment [AD1]: Why not link mental health problems to various stages of a girl's development – from the dismay at the birth of a girl to the menopausal problems, the depression of the empty next?

discharge do not have reproductive tract infections, which can account for these symptoms. Thus, it is possible that these women are using the reproductive somatic idiom to seek help from medical professionals and to escape albeit temporarily, from a stressful situation. In extreme situations, women may use sickness as an excuse for refusal of sex or inability to perform household chores. Non specific gynaecological symptoms such as chronic pelvic pain with no identifiable cause can also be a source of psychological distress and anxiety in women. This was a finding of a 1996 study in India carried out among outpatients seeking gynaecological services from three Delhi hospitals.[3]

➢ **Childbirth and Mental Health:** Women are vulnerable to suffer depression during the period immediately following childbirth. Most research on post-natal depression (PND) is from industrialized countries, and demonstrates that PND can be detected in about 10-20% of mothers. The majority of PNDs are self-limiting though, if untreated, the resolution may take up to 6 to 12 months. The detection of PND is of great public health interest not only because of its profound impact on maternal and child health but also due to the abundant evidence that simple inexpensive interventions such as counseling are of significant benefit and help prevent some of the adverse outcomes associated with PND. The current child-oriented post natal care package may ignore the mother's mental health condition and also renders the mother less likely to discuss her own distress since it may be viewed negatively by her family and health workers.

➢ **PMS, Menopause, and Mental Health:** The combinations of emotional, behavioral, cognitive and physical changes occurring pre-menstrual have been designated as a syndrome- the premenstrual tension syndrome (PMS). Typical symptoms of PMS include irritability, mood swings, poor concentration depression and tiredness. The symptoms complained of by women in the menopause - headaches, weepiness and depression, irritability, anxiety, insomnia, fatigue, lack of sexual feeling- are conditions which are just as real and which can be even more worrying than the other major symptoms attributed to menopause such as hot flushes, vaginal dryness and osteoporosis (porous and fragile bones). Several factors might contribute to increased psychiatric morbidity at menopause including life events such as death, poor physical health, altered roles or a disturbed relationship. Hormonal Replacement Therapy (HRT) helps reduce the physical problems but does not do much to help relieve mental health problems associated with menopause. It is worth noting that older women, past the menopause, are often at high risk of depression due to a number of reasons such as loneliness.

➢ **Reproductive tract Surgery and mental health:** Women who undergo reproductive tract surgery such as tubectomy, mastectomy and hysterectomy may face mental health related problems. Gynecological surgery poses a unique stress for women because of the identification of

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[3] Agarwal P, Kahstigar U, Bhatia MS, et al, Psychological profile of females with chronic pelvic pain. Indian J Psychiatry 1996;38(4): 212-16

the reproductive organs both with sexuality and with the wider concept of feminine identity. This stress is particularly apparent when one considers mastectomy or hysterectomy. Of all cancers, breast cancer is arguably the most frightening for women. Mastectomy involves emotional trauma of losing a breast, in addition to numbness of the skin, scarring, and posture problems. Nothing can restore the sexual and nursing function of the lost breast, even if reconstruction of the breast for appearance is possible. Counselling may help ensure optimal sexual outcome for women undergoing such surgery. A number of negative responses to a caesarian delivery among women have also been reported. These responses include fear, disappointment, anger and lowered self-esteem; In addition to the stressors that women have to cope with may have occurred on top of a long and exhaustive labor.

➢ **Abortion and pregnancy loss:** Although grief has been understood and documented for many decades, only recently have the full impact and consequences of pregnancy loss been appreciated. Unique aspects of pregnancy losses surrounding miscarriage and ectopic pregnancy, stillbirth of neonatal death include: real (actual) loss of a person; and symbolic loss (of the future) in addition there is a loss of self-esteem resulting from the woman's inability to rely on her body and give birth. Emotional shock, feelings of loss, sadness, emptiness, anger, inadequacy, blame and jealousy are common feelings experienced after post-neonatal loss. Each pregnancy loss may mean that there is no recognizable body to visualize, and this further complicated the mourning process. Symptoms suffered by women in the case of stillbirth and neonatal death includes depression, sleep disturbance, social withdrawal, anger, guilt and marital disturbance.

Childlessness and infertility

Childlessness leads to stigmatization, divorce, abuse, resentment, loss of social status and self esteem. The experience of childlessness or infertility may lead a woman to intense grief and hopelessness because of the social stigmas attached to it. The woman who is infertile is blamed, tortured and faces physical and emotional violence in their relationships, both marital and communal, for example,

- Pressures and anxiety of elder members
- Rude comments or teasing by people in the society
- Harassment and ragging by in laws.
- Instigation of their husbands by in-laws for remarriage
- Insistence by friends and neighbours for early consultation of doctors
- Late marriages were additional causes mentioned for early initiation of treatment.

Several researchers have drawn attention to the association between infertility and childlessness and mental health, especially in societies that are quick to single out women as the lone cause for this. A barren woman is often looked down upon, especially if she is also illiterate and unable to contribute financially to the family.

➢ **Adolescent Sexuality and Mental Health:** The sexual health of adolescents is rapidly becoming the newest "buzz" word in reproductive health research. However, there is a risk that the agendas and priorities of reproductive health workers may miss out on the other real concerns of adolescents and their families, viz., stress arising from conflict within families and from pressures in the educational system and rising unemployment. There is now substantial evidence pointing to the rising rates of depression and suicide amongst young people. Suicide has become of the commonest causes of death and hospitalization in adolescents in many societies. Pressures of academic performance can lead to considerable psychological stress and symptoms of weakness, lack of concentrations, headaches and so on. Peer pressure is an important factor that influences the mental health of adolescents. Peer pressure can force an adolescent to experiment with sexual behavior in order to be accepted in the peer group. Peer pressure can also force an adolescents dealing with their homosexuality can be especially vulnerable to mental health problems as they have to cope with their sexuality and other related issues with little support or approval. Anxiety around pubertal changes may also cause mild to severe mental health problems in the adolescents. They often worry about matters such as menstruation, masturbation, and delay in the onset of puberty, size of breast, penis and so on. Young men sometimes believe that semen is a source of physical strength and vitality. They become very concerned when they notice that they are "losing" semen by passing it in their underwear during the night, or when passing urine or stool. They may become very anxious about their desire to masturbate and, if they do masturbate, suffer guilt and tension because of this. Many men will go on to complain of tiredness, aches and pains, impotence and suicidal feelings. Typically, they will blame these complaints on the passing of semen (Also called "dhat" in North India) in their urine.

➢ **HIV/AIDS and Women's Mental Health:** HIV/AIDS produces mental health problems in those who suffer from the disorder for a variety of reasons including the stigma and discrimination associated with the disorder, the obvious implications of diagnosis to long-term survival, the impact of discovering an illness which may have already infected loved

ones in the family, and the direct and indirect effects of the HIV. The effect of caring for terminally ill persons on the mental health of carers is now recognized as an important cause of depression. There are growing reports that women, who are often carers for persons with HIV/AIDS, suffer considerable mental and physical health problems as a result of care giving and that depression, in particular, is common.

➤ **Family Violence and Mental Health:** Violence against women is emerging as a pervasive global issue and contributes significantly to preventable morbidity and mortality for women across diverse cultures. There is now substantive evidence demonstrating that amongst the most disabling and long-lasting health effects of violence are mental health effects such as depression and Post Traumatic Stress Disorder (PTSD): other recognized mental disorders associated with violence are eating disorders, sexual dysfunction and suicidal behavior. The psychological effects of violence range from mild to severe types of mental distress. Cognitive effects of victimization may include shock, anxiety, fear, emotional numbness, confusion, helplessness, denial, a sense of betrayal particularly if the assailant is an acquaintance, a sense of shame, guilt and humiliation, especially in societies where rape myths abound; insecurity, a feeling of worthlessness, self blame, self hatred and causing injury to one-self, especially in case of being battered in a relationship, withdrawal, loosing capacity to care, and for intimacy and trust, phobias, lost of interest in or fear of sex, social isolation and other difficulties in relationship, dramatic changes in social/interpersonal behavior, particularly with other men.

The harmful impact of sexual violence and abuse in childhood has been shown to lead to mental illness in adult life. There is evidence that women who have been abused have difficulties in forming trusting, stable relationships and may land up in more abusive relationships in the future. Friends and relatives can be very helpful if they suspect an abusive situation. Support groups and counseling both can help a person in an abusive relationship. People in same-sex partnerships also face abusive relationships and may need such help.

➤ **Rape and Mental Health:** Rape is one of the most terrifying experiences that any human being can experience. It is not only a violation of a woman's body, but of the most sensitive aspect of her being, her sexuality. In many communities, the woman suffers the double blow of suffering rape and then being accused or discriminated against by other members of her community. In this sense, rape involves both physical violence and mental torture, it can be extremely damaging to a

woman's health. Typically, a woman goes through a series of emotional reactions. The woman may be tearful, shaking with fear and anger and unable to understand what she has just experienced. Some women may appear calm and controlled; this does not mean that they have coped well with the rape. In the days and weeks after a rape, a variety of emotions are experienced. Blaming oneself, fears of being killed or harmed, feeling of humiliation, feeling dirty, repeated thoughts of the rape, nightmares and sleep problems are common. Physical complaints such as aches and pains, loss of appetite and tiredness are also common. Later on the woman may develop a fear of people behind her, fear of situations similar to those in which the rape occurred and so on. As a woman recovers her self-esteem, often sadness and tear remain for a long time. Lot of women may find difficult to enter into stable relationships, may have flash backs, panic attacks as a post traumatic effects of rape. Few realise that psychiatric injury can be even more devastating than physical injury; however, prospects for recovery are good, especially when the survivors are in the company of fellow survivors or those with genuine insight, empathy and experience. In the end the majority of woman do recover from the trauma but not without having suffered severe ill-effects for a long time.

➢ **Child Abuse & Mental Health:** Both male and female children can be victims of child abuse. Abuse can be emotional (such as neglect), physical (such as beatings), or sexual. Children who are abused usually appear the same as those who are not abused. However on closer examination they may appear to be tensed and unhappy, present with deterioration in school performance, and may complain of a number of physical symptoms such as stomachaches, headaches, sleeplessness, and eating problems. In adolescents, antisocial behavior and drug abuse may be signs of abuse. Some may become troublesome at school or steal. Many children blame themselves for the abuse that they see in their households. Children in abusive households may have more trouble dealing with their anger.

Issues and Concerns in Women and Mental Health

Inhuman Treatment of Mentally Ill Persons

The way a particular society treats persons with mental health problems reflects larger societal attitudes towards mental illness. Historically, there were no theoretical basis to understand mental illness and 'abnormal' behaviour (associated with mental illness) was considered socially unacceptable and evil. Persons with such problems were often cast out by society into jails and asylums. A common way of dealing with persons with mental health problems was to 'commit' them to an institution (asylum or jail) and the power to make the decision was given to the magistrate strengthening the association with criminal behaviour. Persons with mental health problems were treated in the most inhuman manner in these asylums, and this has been a historical phenomenon. Eugenic sterilization has been a common response to mental illness. Though humane methods in the treatment of mental illness started as early 1793 in Paris by Phillipe Pinel, mentally ill persons even today, are routinely chained, beaten up, kept naked and even subjected to often un-necessary electro-convulsive therapy (ECT). Terms associated with the mentally ill person, no matter in which language, are used in a derogatory manner

As recently as 1999, a National Human Rights Commission inquiry on the condition of mental hospitals reported horrifying abuses of mentally ill women in some large asylums. These included the inappropriate use of ECT (shock therapy), sexual abuse of patients and gross neglect of medical care. The NHRC report also noted that a number of jails in the country had mentally ill persons who did not receive any treatment or care. It is important to keep vigilant of whether the recommendations of the commission are implemented in the years ahead. Some other important legislative changes in recent years include the revision of the Disability Act to include mental disorders, and the rewriting of the old Indian Lunacy Act into the Mental Health Act of 1987 (in force from 1993) to be more sensitive to the needs of mentally ill people.

The Rights of The Mental Ill

It is clear from the earlier discussion that mentally ill persons have enjoyed very little by the way of human rights. Persons with mental illness are especially vulnerable because of their disturbed mental state, which prevents them from making reasonable judgments about their own needs. As a result, mentally ill persons are often given least priority in terms of access to care and services. It is true that mentally ill people can sometimes be dangerous to themselves or to others, although this hazard is often greatly exaggerated. The second important reason for protecting the human rights of persons with mental illness is because they are stigmatized, discriminated and marginalized. The international community accepted a set of principles for the protection of persons with mental illness and for the improvement of mental. The principles attempt to set forth safeguards against such hazards without ignoring the fact that such provisions are particularly liable to be abused by family members, other members of the community or state authorities. If a national jurisdiction follows this balanced set of principles in drafting domestic law and in instituting procedural modalities, both the rights of the mentally ill and improvement in mental health care can be accomplished.

Key points about Mental Health Legislation

- People with mental disorders constitute a vulnerable section of society.
- Mental health legislation is necessary for protecting the rights of people with mental disorders.
- Mental health legislation is concerned with more than care and treatment. It provides a legal framework to address critical mental health issues such as access to care, rehabilitation and aftercare, full integration of people with mental disorders into the community, and the promotion of mental health in different sectors of society.
- There is no national mental health legislation in 25% of countries with nearly 31% of the world's population.
- Legislative issues pertaining to mental health can be consolidated into a single instrument or dispersed in different documents. A combination of both approaches is likely to be the most effective solution.
- Mental health legislation is an integral part of mental health policy and provides a legislative framework for achieving the goals of such policy.

Source : Mental Health Legislation and Human Rights : *WHO 2003*

Indian Lunacy Act 1912 to Mental Health Act 1987

The Colonial Government had set up a number of 'Lunatic Asylums' in India – Madras, Pune, Lucknow, and other places. The Lunatic Asylum Act of 1856 and later the Indian Lunacy Act 1912 were the laws that not only decided how these institutions would be managed but also decided criteria for admission. Lunatic Asylums were later re-christened mental hospitals and the first mental hospital was set up in Kanke, Ranchi in 1935. Mentally ill

persons were not only confined in these asylums but also in jails. A series of media articles highlighted the plight of mentally ill persons in jails, especially in West Bengal and Assam. Later the intervention of the Supreme Court brought about changes in the way these hospitals were run.

Incident at Erwadi

In the early morning of 6th August 2001, a fire broke out in a private mental asylum near Erwadi *dargah* near Ramanathapuram in Tamil Nadu. Twenty eight inmates of the asylum perished in the fire because they were all chained to their beds. When the inmates had raised a cry because of the fire, the managers who mistook it for the usual noise made by the patients ignored it. There were more than 15 such private asylums in the Erwadi area where people brought mentally ill persons and prayed for divine intervention for cure.

The Mental Health Act, 1987 repealed the Indian Lunacy Act 1912, and came into effect on 1 April 1993. Under this new act only those who are dangerous by reason of mental illness (the term dangerous has not been defined), can be detained. Under the Mental Health Act 1987, each state government must establish an authority for mental health services, which shall be under the superintendence, direction and control of the state government. This authority shall be in charge of the regulation, development and co-ordination of the state's mental health services; supervise those psychiatric hospitals and nursing homes under the state government's control; advise the state government on all mental health matters; and discharge any other functions the state government may require.

There have been problems implementing the new provisions. The Act stipulates all mental patients are eligible to the services of a lawyer (to be provided by the state, if necessary). However, it has been reported that not a single patient has yet been represented by a lawyer.

Human Rights and Mental Health Act, 1987

While the Mental Health Act 1987 does not explicitly mention the human rights of mentally ill persons it does include some rights. Some of these rights include the following

- No mentally ill persons shall be subjected during treatment to any indignity whether physical or mental or cruelty.
- No mentally ill person under treatment shall be used for the purpose or research unless such research is of direct benefit to diagnosis or treatment, or the consent is given voluntarily.
- A mentally ill patient shall be treated at the expense of the Government if admitted as an inpatient and does not have property.
- a mentally ill person has the right to legal counsel at the expense of the State in the District Court.
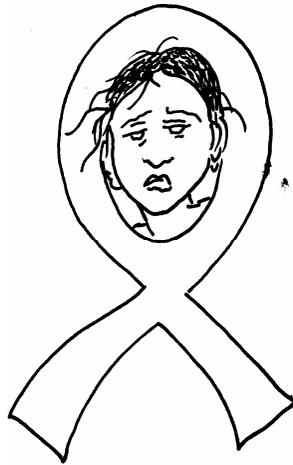
However the Mental Health Act does not cover neglect or cruelty to mental patient sustained in families or alternate system of care like magicians, healers and quacks. The Act also does not spell out any minimum standard of care and treatment that such persons should be entitled to – and no provision of accountability for any negligence in the care and treatment of inmates of asylums. The provision for legal aid is restricted to proceedings before a District Court or a Magistrate and no mention is made of High Court or the Supreme Court. The Act excludes from its regime the mentally retarded. It also does not differentiate between the various degrees of mental illness. There is no provision for compensating those wrongfully detained or negligently treated. The Act makes has no mention of the right to rehabilitation of those discharged after being found fit. The property rights of the mentally ill are not adequately secured.

Objectives and Strategies of the NMHP

Objectives
1. To ensure availability and accessibility of minimum mental health care for all in the foreseeable future, particularly to the most vulnerable and underprivileged sections of population.
2. To encourage application of mental health knowledge in general health care and in social development.
3. To promote community participation in the mental health services development and to stimulate efforts towards self-help in the community.

Strategies
1. Integration mental health with primary health care through the NMHP
2. Provision of tertiary care institutions for treatment of mental disorders
3. Eradicating stigmatization of mentally ill patients and protecting their rights through regulatory institutions like the Central Mental Health Authority.

Women and Mental Health Policy

The Government of India launched the National Mental Health Programme (NMHP) in 1982, keeping in view the heavy burden of mental illness in the community, and the absolute inadequacy of mental health care infrastructure in the country to deal with it. The aims of this program were –
1. Prevention and treatment of mental and neurological disorders and their associated disabilities.
2. Use of mental health technology to improve general health services.
3. Application of mental health principles in total national development to improve quality of life

The current National Mental Health Programme prioritises the severe mental disorders like epilepsy and psychosis, whereas it is the common mental disorders that are frequently found among the women in particular and the community in general, The national policy reflects the priorities of international organisations, which is informed by cost-effectiveness of implementation of policy rather than community need. While severe mental disorders are more easily managed through the mental health and primary health care infrastructure already available, common mental disorders require insight into the social reality of the patient. Pharmacological interventions cannot be used in isolation, and often, counselling and family therapy, may be required. All this needs long term social planning and considerable shift in the current training and curricula for health workers of all grades.

However, the NMHP remains largely unknown outside psychiatric hospitals, defeating its very purpose. The NMPH needs to be rectified so that its goals and methods are altered from a medical model to a psycho-social model, from a psychiatric oriented model to a community health oriented model, and from making a purely clinical commitment or making a social commitment. These are issues which must involve both mental health professionals and women's activists so that they can collaborate for framing better health policy. It is necessary to bring about a radical shift from the medicalised mental health practices, such as mental hospitals to the social model of community care.

Mental Health Services and Care

While the NMHP is grossly inadequate in both design and coverage to meet the mental health needs of women, the marginalisation of women's mental health is also present in non-government programmes. Very few health programmes, including women's health programmes and projects address women's mental health issues. While it is true that the level of knowledge and information is low but many health activists also dismiss mental health as being not as significant as the more urgent issues like maternal health or tuberculosis.

In India, the family has been the most important institution involved in the care of its mentally ill. Due to inadequate mental health facilities, most patients have lived with their families who have provided the attention and care in times of need. However, for some women, family attitudes may make their care doubtful or even harmful. Furthermore, there is also the need for professional care for many types of mental illnesses. In addition, families caring for the mentally ill also need guidance and support. Thus, there is a need for systematic organisation of essential services for mentally ill women especially those living in rural, tribal and urban slum areas. Requirements of working women and girls on the street represent another group who require innovative approaches to meet their mental health needs. There is a need for innovative, cost effective services, which are in harmony with existing socio-political and cultural norms. This is more likely to be achieved by thinking in terms of local initiatives, appreciating the power of micro-planning at the villages/grass root level, rather than orienting towards centralised plans, programs and projects.

Mental Disorder- Disability or Illness

There is an attempt by mental health experts from the development sector to stop referring to all mental disorders as mental illness and to also use the term 'disability' for psychological ill health. This can prevent over medicalisation of women, and also ensure that the state provides measures to overcome the disability. The organization, SCARF, has developed a tool called IDEAS *(Indian Disability Evaluation and Assessment Schedule)* which was adopted by the Government of India in 2002. The Persons with Disabilities Equal Opportunities Act 1995, also provides opportunities for developing non-discriminatory and equal opportunity mechanisms for persons with mental disorders.

During the last two decades, a number of innovative approaches have been developed to meet the different needs of people with illnesses, to prevent mental disorders and to promote mental health. Some of these innovations are described in detail in the book. The overall picture is one of tremendous scope, positive initial experience and the need to enlarge and over larger groups of population all parts of the country. The key to sensitive mental health care delivery for women lies in two major programme areas; first, the inclusion of mental health as a priority in existing community and women's health programmes and second, the sensitization of health workers to the unique mental health needs of women and the need for a revision of the NMHP to accommodate these needs.

Gender Bias in Mental Health Services

Mental health is relatively a newer area of research and practice in the history clinical medicine. Service issues for the mentally ill women can be understood only in the context of the history of the available laws and policy for regulating mental health practices. The mental health sciences are linked in a complex and varied ways with the services. Therefore the question of

gender bias poses more of a clinical problem in terms of actual treatment settings.

There is considerable evidence to show that women experience gender-related constraints on their access to health services and that this affects the poorest women in particular. Women face comparatively lower detection and referral rates in primary care settings. The obstacles they face include lack of culturally appropriate care, inadequate resources, lack of transport, absence of alternative care for their families and sometimes the refusal of their husbands to give permission. Of course limited public expenditure on health care will affect men as well as women but in conditions of scarcity it is often the females in the family whose needs are given the least priority.

If they do gain access to health care, there is also evidence that the quality of care women receive is inferior to that of men. Gender related stereotypical attitudes and beliefs of the physician also influences examination, diagnosis and treatment. There is often a tendency to trivialize women's suffering. Too many women report that their experiences are distressing and demeaning. Medical knowledge is too often presented as inevitably superior, giving women little opportunity to speak for themselves or to participate actively in decision making about their own bodies. These problems are reflected particularly in the context of reproductive services where dehumanising and insensitive treatment can affect women's willingness to return. Physician biases can end up in women receiving higher rates of prescription with psychotropic drugs.

Providing Services for Mental Health

Mental health services: Key Points

Mental health services can be broadly categorized as: (a) mental health services integrated into general health services; (b) community-based mental health services (c) institutional services provided by mental hospitals.

- Mental health services in primary care require significant investment in adequate human resources and appropriate training for primary care professionals.
- Good clinical outcomes for many mental disorders are possible through services delivered in primary care settings.
- Mental health services in primary care enjoy significant advantages of access, acceptability and lower financial costs for both providers and users.
- Mental health services in general hospitals require the presence of trained mental health professionals in sufficient numbers.
- Formal community mental health services need close working links with primary care and with secondary and tertiary hospital-based services.
- There is usually a high degree of satisfaction with well-resourced community services among users and their carers.
- The provision of community-based mental health services does not produce immediate cost savings for service providers.
- Providers of informal community mental health services are a readily available resource in many countries.
- Informal community mental health services are the first contact and sometimes the only providers in many developing countries.
- Specialist hospital-based services are needed in most countries although the absolute requirement for them differs between countries and is significantly lower than that for primary care and community- based mental health services.
- Dedicated mental hospitals are associated with stigma and human rights violations in many countries.
- In many countries, dedicated mental hospitals consume a disproportionate amount of financial and human resources, with the result that little scope is left for the development of alternative services.

(*From* WHO (2003) Mental Health Policy and Service Guideline Package-Organising Services for Mental Health, Geneva, WHO)

Alternative and Complementary Therapies for Mental Health

There is some debate on the extent to which drugs are useful in the whole range of mental illnesses. While most authorities agree that severe mental disorders do require drugs, many common medical disorders can be managed

with alternative therapies. Proponents of alternative approaches believe that mental health is the result of the inter-relationship between mind, body and spirit. Complementary therapy refers to additional therapies (to orthodox western medicine) that support medical therapy. Some of these include Self help groups of persons with similar needs, Diet and nutrition, Religious counseling, Art therapy, Dance therapy, Yoga, Ayurveda, Meditation, Biofeedback, and so on.

Research on Alternative / Complementary Therapies

Research already exists to show the usefulness of some of these therapies.
- Acupuncture can have a positive impact on some persons suffering from Schizophrenia
- Homoeopathy has been shown to be useful in some people with severe mental health problems, if used side by side with anti-psychotics
- Herbal medicines have been linked to relief of mild to moderately severe depression
- Massage has been shown to relieve anxiety, stress and depression in some people
- Reflexology has been shown to relieve stress and anxiety and relieve the side effects psychotropic medicine and moderate mood swings
- Research into nutrition and dietary medicine has demonstrated that food sensitivities can cause mental health problems.
- Transcendental meditation, hypnotherapy, yoga, exercise, massage, aromatherapy etc. have some effect in reducing stress, tension and anxiety.

(**Source:** http://www.mentalhealth.org.uk/page.cfm?pagecode=PMSTCO)

Women and Mental Health – Need for Advocacy

Not so long ago mentally ill persons without any criminal records were locked in jails in our country. This situation has now changed because the media and the citizen took it upon themselves to raise the issues. Many of the changes in mental health related laws and programmes that have taken place in India, are a result of the pressure created from the media and from citizens who have gone to the extent of filing Public Interest Litigation in the High Courts and Supreme Court. The Mental Health Act and its implementation, the National Mental Health Policy and its implementation still need change. The incident of Erwadi, which took place long after the laws had been amended and the policy was in place, highlights the importance of engaging in mental health advocacy.

Some of the issues for advocacy on mental health include the following:

Use of Electro Convulsive Therapy –Electro Convulsive Therapy is a method of treatment of psychiatric illness in which electric current is passed across electrodes held across the head (with or without anesthesia). The shock

induces convulsions. This treatment (especially that without anaesthesia and muscle relaxants) is known to cause injuries. While this form of treatment is banned in the west it is still used in many places in India.

Use of alternative therapies for women with mental disorders – Common mental disorders may not need medicines and may be the result of the stress that women face. Alternative therapies which include psychosocial support, nutrition and food, yoga have been found to be very useful.
Pix5
Developing comprehensive mental health law and policy with provisions for community-based care – The need for changes in the Medical Health Act and the National Mental Health Policy is being discussed by a number of groups

Minimum standards of care and accountability in mental health institutions – The National Human Rights Commission has taken a number of steps to investigate the rights of mentally ill persons, particularly those in mental health hospitals and institutions. Some of the studies conducted by the NHRC include

- Quality Assurance in Mental Health
- Programmatic Intervention for the abandoned patients in three mental hospitals
- A study related to mentally ill persons in West Bengal

For additional information on women and mental health related advocacy please get in touch with
Dr Bhargavi Davar,
Center for Advocacy in Mental Health,
Bapu Trust for Research on Mind and Discourse
B-1, 11/12Konarak Pooram
Kondhwa Pune, India 411 048
Phone- 020-26838644; 26838647
Email wamhc@vsnl.net

Women and Mental Health Research: An agenda for the future

Future research must explore and determine the linkages between mental and reproductive health. A key area for any research investigation in mental health is examining its relationship with cultural factors. Concepts such as depression, can be elicited in different cultures, but may mean something quite different; for example, it may reflect the patients assessment of their socio-economic and spiritual state. As a result, persons with depression rarely consult mental health professionals and tend to use somatic idioms such as vague aches and pains. Therefore, it is essential to generate a local language of depressions and to explore its contextual significance and the explanatory models of the depressed individual; what the person believes is causing her distress, her understanding of the changes that are affecting her and how the distress has affected her daily life. Epidemiological research in itself has severe limitations in accurately describing women 's mental distress, such as posttraumatic stress disorder or major depression that are linked to socio-political and economic realities. Feminist perspectives on women's health underscore the importance of "treating survey methods for

their gender bias" and using more innovative instruments to collect accurate quantitative data on women's mental distress. In this respect, ethnographic research may also be valuable in exploring reasons why women are more vulnerable to suffer from Common Mental Disorders and the mechanisms by which these disorders lead to disability. Several themes and hypotheses for research are considered below.

- How common is postnatal depression? Which women are more vulnerable to suffer PND? What is the impact of postnatal depression on infant and maternal health? What is the role of fathers in this context?
- What are the fears and desires that women have regarding their own bodies and sexual lives? How do researchers and programmers incorporate emotional aspects of sexuality into the reproductive health parading?
- What are the health priorities and concerns for adolescents? What is the relationship between gender, dropping out of education, stress related to education and mental health? How do these factors interact with sexual and reproductive health in adolescents?
- What is the relationship between the common complaints of white vaginal discharge and weakness with mental health? Are these idioms for psychosocial distress? If so, do women benefit from receiving mental health interventions for these symptoms?
- What are the mental health consequences of domestic violence? Can family or marital therapy interventions help in these situations?
- What is the relationship between infertility and mental health? Can counselling interventions help couples with infertility problems?
- What is the mental health impact of AIDS for women, both when they are themselves suffering from the disorder as well as the impact of being carers of relatives with the disorder?
- What is the impact that community based interventions for either reproductive or mental health issues have on both health outcomes?
- What is the impact of reproductive tract surgery and abortions on women's mental health? Can counselling help reduce this impact?

Many women's health activists are of the opinion that women's health needs should not be compartmentalized into "reproduction", "mental", "physical" and so on. It can be argued that such categories are created more to satisfy the needs of researchers and activists whose experiences and training have been compartmentalized, than to cater to the real needs of ordinary people. Thus, reproductive health research and programming will need to incorporate mental health and mental health research and programming will need to incorporate reproductive health. The many potential themes of intersection of these two crucial health domains provides an avenue for exploring these issues without risking the stigmatization of women who would, otherwise, not wish to be associated with "mental illness". While it may be premature to suggest interventions that address mental health issues, reproductive health researchers should take the initiative to provide sufficient evidence to policy makers and health programmers that women have minds too.

For additional information on women and mental health research please get in touch with:

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Email: vikram.patel@lshtm.ac.uk

Or

Dr R Thara
Schizophrenia Research Foundation (India)
R-7A North Main Road
AnnaNagar West (Extn.)
Chennai 600 101
Tamil Nadu, India
Phone: (91-44) 26153971; 26151073
Email : scarf@vsnl.com

Resource Section

Further Reading

Books

Agarwal, S.P. 2003 Mental Health: An Indian Perspective 1946-2003 ; New Delhi: Elsevier India Private Ltd.

AINA: A Mental Health News Letter; Centre for Advocacy in Mental Health, Pune

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Patel, V. (2003)Where There is No Psychiatrist. A mental health care handbook for the community health worker Gaskell, London

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WHO (2002) Women's Mental Health : An Evidence Based Review, WHO Geneva

WHO (2000) Women of South-East Asia ; A Health Profile, New Delhi, WHO SEARO

WHO (2003) Mental Health Policy and Service Guideline Package-Organising Services for Mental Health, Geneva, WHO

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Mitchell G. Weiss et al (2001*) Global, national, and local approaches to mental health: examples from India, *Tropical Medicine & International Health Volume 6 Issue 1*

Resource Organizations

Institutions	Contact details
The Disability India Network (DIN) is managed by the Society for Child Development, a registered non-governmental national level organization. The Network has a dynamic register of services that is free for the use of all. More than 3000 organizations are already part of this growing database.	Society For Child Development Cottage 15, Oberoi Apts 2 Sham Nath Marg Delhi 110 054 Email: webmaster@disabilityindia.org
The National Institute of Mental Health and Neuro Sciences (NIMHANS) was established in 1974, as an autonomous institution. The district model developed by the Institute is now implemented in four states, and is being extended	NIMHANS Hosur Main Road Bangalore East Tel: 91-80-26995000 Web: www.nimhans.kar.nic.in

to seven more states. A number of projects to study the effect of Ayurvedic medicine in treatment of psychiatric and neurological disorders have been carried out, and an Advanced Centre for Ayurveda in Mental Health and Neurosciences at NIMHANS has been established.	
The Indian Council for Mental Health (hygiene) (ICMH) as established at Mumbai in 1944. It is a not-for-profit, open-to-all, service organization dedicated to the principle that 'medication alone is not the sole remedy for emotionally mentally disturbed people; psychotherapy and counseling has a major role to play in their cure.' ICMH provides counseling, educative films for students, psychoanalysis and therapy.	UPM School Building, 1st Khetwadi Lane, S. V. P. Road, Girgaum, Mumbai - 400004 Maharashtra, INDIA Phone: 91 22 3855205 Fax: 91 22 3861087 e-mail: icmh1@rediffmail.com
National Association for [the] Mentally Ill (NAMI) - The objectives of NAMI are to eradicate the stigma associated with mental illness; to make treatment and medication available to all sections of society; to support the rights of persons who are or have been treated for mental illness; and to help reintegrate into society people who have a mental illness	3A, Shimpla 35/161, Juhu Versova Link Road Andheri(west) Mumbai 400053 Tel: 91-22-26288620/ 9820340115 email nami@namiindia.com Web: www.namiindia.com
Centre for Advocacy in Mental Health CAMH is working on projects that address the needs of community-based organizations working in the area of 'women and mental health.' It is also undertaking research, and developing documentation, in areas such as 'mental health and youth', 'disability and mental health', 'women's experiences of mental health services' and 'the media and mental health'.	B 1/11, 1/12, Konark Pooram, VI Floor, Kondhwa Khurd, Pune 411 048 Maharashtra India Tel: 0091-020-26837644; 26837647 Email: info@camhindia.org , wamhc@vsnl.net Website: www.camhindia.org

The Schizophrenia Research Foundation (SCARF) is a non-governmental, non-profit, organization in Chennai. The foundation built a comprehensive mental health centre in 1998, which includes an out-patient clinic, a day care centre, a research wing, training and education centre, a library and an auditorium.	Schizophrenia Research Foundation (India) R-7A North Main Road AnnaNagar West (Extn.) Chennai 600 101 Tamil Nadu Tel: 91 - 44 - 2615 3971 Fax: 91 - 44 - 2615 1073 Email: scarf@vsnl.com Web: www.scarfindia.org
Sangath Society conducts research on psychosocial health problems of public health significance. The research findings are disseminated using a variety of methods, including articles in scientific journals and academic conferences, workshops with users and consumers, training materials for health workers, handouts and brochures for families and so on.	Sangath Centre 841/1, Alto Porvorim, Bardez Goa- 403521. India Tel: +91 – 832 – 2414916 Fax no. +91 – 832 - 2411709 Email: contactus@sangath.com Website : www.sangath.com
IFSHA (Institute for Support, Healing & Awareness) Works on sexuality and gender issues through research, counseling, awareness-raising programs etc.	J-39, South Extension Part - 1, New Delhi 110 049. Tel/Fax: 011-6253289/98. Email: ifsha@vsnl.com sehar@del3.vsnl.net.in

Mental Health Services

Mental Health Services are available in local medical colleges or psychiatric hospitals in many parts of India. Some other contact addresses and resources in the non-governmmental sector are:

1. **Alzheimer Diseases & Related Disorders Society of India** (ADRDSI): Dr Jacob Roy, Villa Tropicana, XV/496 Thrissur Road, Kunnamkulam, Kerala 680502: Works in the field of family support and care for patients with Alzheimer's Disease.
2. **Antarnad:** Dr Apoorva Shah, 402 Shikhar, and nr. Mithakali Six Roads, Navrangpura, Ahmedabad: Works in the field of psychotherapy and child mental health
3. **Forum for Mental Health Movement:** Ms Ratnaboli Ray, 93/2 Kankulia Road, Benuban#A302, Calcutta 700029: A collective of NGOs working in mental health and allied fields

4. **Medico-Pastoral Association**: Lata Jacob, 47 Pottery Road, Fraser Town, Bangalore: 560005: Provides residental care and rehabilitation for severe mental illness
5. **Mon Foundation**: VIP Road Kaikhali Nazrul Islam Avenue Calcutta: 700052 . Provides services through a clinic and hospital.
6. **Paripurnata:** Dr J Siromoni/Dr S Mukherjee, 5B Swarnamoyee Road, Calcutta 700009. Works for severe mental illness.
7. **Richmond Fellowship Society**; S Kalyanasundaram, Asha, 501, 47th cross, 9th Main, Jayanagar, V Block, Banglore 560041. Provides residential care and rehabilitation for severe mental illness
8. **Samadhan**: Pramila Balasundaram, Day Care Centre, Block F, Main Park, Sector V, Dakshinpuri, New Delhi 62: Works in the field of mental retardation
9. **Sneha**: Dr Lakshmi Vijakumar, 4 Lloyds Lane, Royapettam, Chennai 14. Works in the field of suicide prevention.
10. **TT Ranganathan Foundation**: Dr Anita Rao, 17 IV Main Road, Indira Nagar, Chennai 600020. Works in the field of alcohol abuse.
11. **Udaan -** Provide all round management, help and guidance for children with cerebral palsy and/or mental retardation. Address: A-59, Kailash Colony, New Delhi - 110 048, India Phone: +(91)-(11)-26446978/51631140

Web Resources

Some web resources on mental health that were useful in making this booklet are given below:

Indian	
Central Institute of Psychiatry, Ranchi	www.cipranchi.nic.in
Centre for Advocacy in Mental Health, Pune	www.camhindia.org
Disability India Network	www.disabilityindia.org
Indian Journal of Psychiatry	www.ijponline.org
Indian Psychiatric Society	www.ipsonline.org
National Association for the Mentally Ill	www.namiindia.com
National Human Rights Commission	www.nhrc.nic.in
National Institute for Mentally Handicapped, Secunedrabad	www.nimhindia.org
NIHMANS, Bangalore	www.nimhans.kar.nic.in
Sangath Society Goa	www.sangath.com
Schizophrenia Research Foundation, Chennai	www.scarfindia.org

International	
Alternative Mental Health – Provides resources for alternative therapies. Also provides links to electronic magazine on alternative therapies in mental illness	www.alternativementalhealth.com/
Mental Health Foundation- a website of the organization which includes resources on issues, problems, treatment and help.	www.mentalhealth.org.uk/index.cfm

Mental Health Lawyers: International Resources- provides a wealth of information on laws and policies and institutions working on mental health issues in India	www.mentalhealthlawyers. com
National Mental Health Information Centre – Website of the US Department of Health and Human Services – Substance Abuse and Mental Health Services Adminsitration. Contain many useful references including those on alternative therapies	www.mentalhealth.samhsa. gov
WHO : Mental Health site – provides links to manuals, factsheets, policy papers and many other useful resources	www.who.int/mental_healt h