aaina

a mental health advocacy newsletter

Vol. 2 No. 2 July 2002

Editorial

The "mental health week" will be here soon. Everyone will be talking about the "stigma" of mental illness and "daring to care".

Number one, "caring" is nice, it is healthy and good. It is natural and human to care. The world turns on love, share and care… It is not a "dare".

Number two, about "stigma": Stigma has become a marketable commodity. Families are talking about it, psychiatrists are talking about it … and wait … even drug companies are talking about it. Look up any pharma website which sells psychoactive drugs. Typically, the drill about "stigma" goes like this: "*Mental illness is a disease. Drugs are available to cure this disease. Use the drugs. End stigma*". Backstage, the drug makers, the retailers and the prescribers will laugh all the way to their banks.

Vijaylekshmi, Nasra, Lekshmi, Selvi, Santamani, Rasheea, Pattukani, Sarojani, Anusuya, Gulnas, Vellaisamy, Krishnan, Sonaimuthu, Prabu, Santhanakrishnan, Muruganantham, Parthiban, Arumugam, Lekshmi, Periyasamy, Murugaraj, Samsudeen, Rajan, Thankaraj and Radhakrishnan died, this time last year, just a few weeks before the "Mental health week", in Erwadi, Tamil Nadu. They died of despairing discrimination and physical, emotional and social deprivation, abuse and violence. This is not stigma, as defined in the above clinically sterile and commercially viable way.

If the alternative to "stigma" is a choice between "mental disease" (whatever that is) and crippling drugs, we say, *go* for stigma. Be stigmatised, stay low, hidden, alone, but safe from overprescriptions, irrational drug preparations, poly / multi pharmacy, drugs hidden in your food, depot injections, forced ECT, involuntary commitment, etc. etc.

Suna hai, many airloads of our mental health professionals are landing at Heathrow airport looking for greener pastures. Our professional community has always been lamenting the *crying* need for more professionals, and so which ethical principle of the business justifies this exodus? It is very hard to imagine that needs in the UK are much more than needs here. The downside is that we are about to lose some of the better and the more sensitive carers. The upside is that fewer drugs and ECTs will be forcibly pushed onto communities. *Adios, fellas…*

A Basic Right to Rehabilitation

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Can the new IMC Regulations, 2002 regulate psychiatry? A Report

On 11th March, 2002, the Indian Medical Council has issued a notification on the "Professional conduct, etiquette and ethics" Regulations, 2002. The regulations are applicable to all "doctors with qualification of MBBS or MBBS with PG degree / diploma or with equivalent qualification in any medical discipline". Psychiatry, being a medical discipline, comes within the scope of these regulations.

IMCR, 2002 covers the following chapters- code of medical ethics, duties of physicians to their patients, duties of physicians in consultation, responsibilities of physicians to each other, duties of physicians to the public / paramedical professions, unethical acts, misconduct and punishment / disciplinary action. At the time of registration, every medical professional should issue a written declaration pledging - service to humanity, utmost respect for human life and dignity, service beyond religion, race and politics, upholding patient interest and confidentiality, upholding professional dignity in the community and in peer relations. Formats are given for the issuance of "fitness certificate", maintaining proper medical record and a list of various Acts under which doctors issue certificates. In the appended list, the "Mental Illness Act" [sic!] is mentioned. A complaints procedure is provided for through the IMCR, 2002, including registration of grievance or complaint against an erring professional, method of inquiry, professional peer review, speedy disposal, disciplinary action, deregistration and punishment.

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aaina

a mental health advocacy newsletter

aaina is a mental health advocacy newsletter. Advocacy demands critical, creative and transformative engagement with the state, policy makers, professionals, law, family and society at large. *aaina* will thematically cover issues in community and mental health, NGOs in mental health, self-help and healing, non-medical alternatives in mental health, rights, ethics, policy and needs of special groups. *aaina* provides a forum for user expression of their experiences with mental health services and debates issues concerning rights of persons with psychiatric disabilities. We look forward to meaningful dialogue with individuals and groups alert about these issues.

Those interested in receiving copies of *aaina* may contact us at wamhc@vsnl.net. Write to us with all your suggestions, criticism and viewpoints on the issues covered.

This issue of '*aaina*' was edited by **Bhargavi Davar**.

Regulation of doctor's conduct includes strength of character, qualification and continuing education / competence, meticulous record keeping (mandatory for 3 years). The doctor should prescribe drugs only with generic names and ensure rational prescriptions. He / she should observe the laws of the country, in which context, along with other Acts, the Mental Health Act, the Drugs and advertising related Acts and the Persons with Disabilities Act are specifically mentioned. He / she cannot arbitrarily refuse treatment to a needy patient. He / she must ensure confidentiality, give information to the patient and relatives, share a realistic prognosis, make appropriate referrals following professional protocols (as laid out in the document) and avoid unnecessary consultations. He / she must act in public interest, as a good citizen, be co-operative with authorities as well as with "paramedical" services. In the paramedical services "pharmacy" and "nursing" are mentioned. This is one place where we see RED from the mental health point of view. Our sense is that psychiatrists are too co-operative with the pharmacy industry!!

Unethical acts under the IMCR 2002 are soliciting patients, advertising and publicity, vested interests in approving a drug, medicine or therapy, printing of photograph for publicity, receiving incentives for promoting drugs or treatments. There is a prohibition on promoting "secret remedies", preparations where the formulation is not known to the doctor. It is unethical for a doctor to aid or abet torture, inflict mental or physical trauma on his patient, concealment of such acts by a peer, and euthanasia.

A violation of these regulations, adultery or improper conduct, and any other criminal act is considered as "misconduct" under the regulation and may elicit deregistration, disciplinary action, or punishment. With respect to certification, a very sore point among human rights professionals in the mental health area, the regulation is quite explicit: "Any registered practitioner who is shown to have signed or given under his name and authority any such certificate... which is untrue, misleading or improper, is liable to have his name deleted from the Register". The Drugs and Cosmetics Act is not to be contravened- Specifically, prescribing steroids and psychotropic drugs when there is no absolute medical indication and secondly, selling Schedule "H" and "L" drugs and poisons to the public except to patient, are said to constitute "gross" misconduct.

Misconduct is also attributable to doctors who perform or enable abortions for which there is no medical, surgical or *psychological* indication. Here again, some exploration is required from the psychiatric point of view, because it is *very easy* to find *psychological* indications. Any doctor not able to show medical or surgical reasons, we are certain, would be able to find *psychological* indications quite easily, as this is such a large gray area.

The doctor is urged to uphold confidentiality under all conditions except when a court calls for information, when there is risk to self and community or where there is notifiable disease. In mental health, the "risk to self and community" is mostly left to subjective assessments of professionals and families, so there are issues to be addressed here. Also, breaching confidentiality even if a court orders disclosure has been contested by mental health advocates as violative of patient rights and clinical ethics. Professionals have been urged to maintain patient and professional dignity by further advocating service and legal reform in this area and resisting different pressures to disclose.

The IMCR also prohibits using brokers for procuring patients, making untrue or misleading claims about specialisation, and refers to the ICMR guidelines for proper conduct of drug trials. These are all relevant in the mental health sphere as well. Carer and user groups, organisations acting as friends of persons diagnosed with mental illness, individuals and activists, and mental health professionals, could examine the IMCR 2002 for what it offers by way of professional regulation of psychiatric practise.

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Judgement Watch- I

R Lakshmi Narayan *vs.* Santhi, Civil Appeal No. 5028 (1999) decided on 1st of May 2001 before DP Mohapatra and UC Banerjee, Supreme Court

In yet another apex court case, where the petitioner cited insanity for obtaining annulment of marriage, no one questioned the gumption of the husband and no one talked about the right to life or the right to treatment and care within marriage. Also, the courts have dropped the earlier talk about 'unsoundness of mind', as enshrined in the civil laws, to directly addressing 'mental disorder'. This shift in legal practice has several questionable ramifications.

The appellant, the husband of the respondent, filed a petition seeking a declaration that their marriage was null and void because of the mental illness suffered by the respondent. Section 12(1)(b) and Section 5(ii) of the Hindu Marriage Act 1955 were cited as grounds. The couple parted company after 25 days of marriage. The appellant charged that his wife suffered from a chronic and incurable mental disorder and was not in a fit mental state to lead a married life. Her "drowsiness" and "refusal to have cohabitation" apparently moved him to further investigate and find out that she was suffering since childhood from a mental disorder, a fact which her father allegedly admitted to. The respondent refuted all the allegations, claiming that the respondent's motive was for a bigger dowry and a second marriage. The trial court had dismissed the petition on grounds that the petitioner could not prove unsoundness of mind. While admitting that it had no medical expertise, it did so after having had the "privilege" of watching the respondent give witness, the way she clearly answered questions and her general demeanour.

The appellate court found fault with the trial court for not having considered as "evidence" the prescriptions issued by a psychiatrist from Chennai. Unlike the trial court, the appellate court accepted the fact of separation. It also took serious note of the respondent's admission to having suffered a mental disorder and that she was given depot injections. The case was once more opened.

In the High Court, however, on further contestation by the respondent, the original judgment of the trial court was restored. The High Court mainly considered whether the appellant was aware of the mental disorder of the respondent before the marriage. It held that the marriage was not vitiated by fraud or misrepresentation, as the husband had ample opportunity to interact with the respondent. The Court did not accept that the respondent was suffering from a chronic and incurable mental disorder and that there was no cohabitation.

The appellant filed in the apex court, assailing the judgment of the High Court under Article 136 of the Constitution. After studying the relevant sections, and dismissing the husband's appeal, the Supreme Court held that these sections, if established in a court of law, do disentitle the party to a valid marriage. Since marriages are voidable (and not per se null and void) using these sections, such cases "in the very nature of things call for strict standard of proof", the onus of bringing such a case before the court and the proof being "very heavy" on the party seeking annulment. The court pledges to examine the matter with "all possible care and anxiety".

Accepting as facts both the presence of mental disorder as well as the separation, the apex court held that this was no basis for inferring that the respondent was unfit for marriage and the procreation of children. It would be, in the court's view, an unreasonable and impermissible inference. To make this inference, it needed to be further established that the ailment is of such a kind or to such an extent that it is impossible for her to lead a normal married life. It would be fair to read the law in this manner, according to this honourable court. The relevant sections and the burden of proof enshrined in them require a far more stringent interpretation than that accepted by the appellate court. Further, the High court may also be faulted for not formulating an appropriate question before law as mandatory. However, considering the manner in which the case has proceeded until the high court, the court could not be faulted for having dismissed the petition and the apex court did not find this a fit case for interfering with the HC judgment. The appeal was dismissed.

Jyoti Dutt from New Delhi shared these materials with Aaina sourcing from Supreme Court Cases (2001) 4 SCC pp. 688-693

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An angry user gives 5 reasons for the close links between psychiatry and forced treatment

Notes from "Noah"

> Once a person is declared mentally unfit, that person loses the right to say "no" to psychiatric treatment, loses the right to various aspects of his own life and loses the right to litigation or to question the diagnosis and treatment he has been given. That person literally becomes a *persona non grata* and loses citizenship overnight.

Historically the State has always been oppressively paternalistic in its attitude towards persons labeled with mental sickness. Most laws, including the Indian laws, are testimony to this. What is so special, so abhorrent about the "mentally ill" that they have been singled out among a million others who fall sick everyday? For example, why is someone suffering from diabetes or cold allowed the luxury of seeking homeopathic treatment or even trying homegrown herbal remedies? Any ill person is just ill and therefore, has to be treated without compromising his freedom in any way whatsoever.

Firstly, unlike other people suffering from physical diseases, the "mentally ill" are supposed to have lost their capacity to take responsible decisions.

Secondly, psychiatry, not so respected within the hierarchy of all medical disciplines, and in its strife to be like a true science, has produced a dichotomy between the body and mind, where the mind is reduced to a mere brain. Psychiatry has very little to do with the mind. The "psyche" part has all but been surgically removed from it. Psychiatry is rooted in German experimental psychology, racist eugenics theories, and anti-human materialistic opinions parading as scientific facts. The promotional activities and tremendous profits of the major drug companies must be clearly recognized for any accurate understanding of the expansion of psychiatry. Psychiatry ignores all comprising man's "inner" world of thoughts, feelings, values, aspirations, hopes, dreams, fantasies, desires, intentions, goals, and ultimately, life itself.

Thirdly, the State, the community and the family have bought this pseudo-scientific rationale lock, stock and barrel. No wonder then, that the unsuspecting public is completely persuaded by the biological and genetic bases of "mental illness".

Fourth, the reason why the State has been traditionally inhuman in their treatment of the "mentally ill" has been because the "mentally ill" have been perceived to be "lesser humans". This is a mindset that still rules in society throughout India, China, North America and other parts of the world. The "mentally ill" by virtue of their temporary and at times, fleeting loss of reason, are the world's most "muzzled" individuals.

Finally, psychiatry, with active encouragement by the State, has a long and ignoble track record of blaming social and economic dysfunction on its primary victims. In the 1800's psychiatry pathologised the tendency of slaves to run away and called it "drapetomania", a "disease" which no doubt called for heroic "therapies". During the industrial revolution, it found its calling in the imprisonment and torturous experimentation on the unemployed poor. Domestic abuse and adverse social conditions are major factors in the creation of "mental illness", yet science continues to prescribe drugs for "unbalanced brains." The modern "scientific-secular" family has reposed its faith in the goodwill of the doctors. It seems, to adapt a quote from Richard Nixon, "If a doctor does it, that means it is medicine."

Everybody believes that the side effects of drugs are transitory in nature. Actually, it is the mental state, which is transitory, yet nobody can believe this except the "mentally ill" themselves! There is also a period of reckoning, introspection, self healing and remission for the person, which again seems incredulous to society. This positive development is naturally attributed to the psychiatric medicines. Even while everyone says that the "mentally ill" must be responsible for their own "treatment" the healing process is credited only to the medicines. All this reinforces the myth that the drugs are harmless, have little side effects and that they work to restore the bio-chemical imbalance in the "mentally ill" person's brain.

There is a fatal kind of paternalism in society which is to the detriment of the "mentally ill". What is seen as a "little" curtailment of the basic human rights, a "little" deprivation of the right to law, a "little" deprivation of rights to inheritance, all these are seen as small losses in comparison to benefits derived from restoring "sanity", whatever that is, by whatever available means.

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"Non-Pharmaceutical Approaches to Mental Health"

Bhargavi Davar

In June, a continuing medical education program of 15 course credit hours on "Non-Pharmaceutical Approaches to Mental Health" was organised by Safe Harbor, a leading non profit organisation in the US educating the public, the medical field and government agencies on the use of alternative mental health. Dan Stradford, the president, in his introduction, pointed out that psychiatry does not take the effects of drugs very seriously. Putting on 60 kilos of weight is a primary and very risky health effect of anti-depressant use, this cannot be called a "side effect" by any standard. Other than the health and brain damaging effects of psychotropics, such drugs do not address the root causes of the mental symptoms, which means life long use of risky drugs to obtain mere symptom relief. The overemphasis on drugs inhibits personal growth, as it limits individual creativity in dealing with crises and it creates an artificial state of mind.

The objectives of the program were to educate on (1) medical conditions that present as psychiatric symptoms (2) hormonal causes of emotional disturbances (3) nutritional treatment and herbal remedies for anxiety and depression (4) lab testing for underlying causes of mental symptoms and (5) sharing case histories of successful recoveries using alternative mental health. Behind the many inspiring and experienced lecture presentations consolidated in this unique program, remains the pioneering work done by biological psychologist Abram Hoffer. The experts were mostly from the fields of psychiatry, psychology, nutrition and biology.

Dr James Croxton, a nutritional psychologist from Santa Monica talked about brain metabolism and the role of nutrition here. He runs a regular course in his university department on nutritional psychology. He also sustained a self help group called 'MANA' ("Mind And Nutrition Awareness") for twelve years. In the program, he introduced the concept of "somatopsychic" phenomena (in contrast to the "psychosomatic"), i.e. mental experiences caused by biological, physiological or medical reasons.

There was a demonstration of the enormous lab testing possibilities in the presentation by Jeff Baker from the Great Smokies Diagnostic Labs. After outlining the molecular basis of what he called "chronic metabolic disorders" -(we call them "mental disorders"!)-, Dr Baker talked about lab testing for amino acid deficiencies, metal poisoning, hormone deficiencies, vitamin and other nutritional deficiencies. It was so surprising to know that chronic candida, a common reproductive tract infection in women, can cause a range of mental experiences including fatigue, poor memory, being "spacey", insomnia, hypersomnia, anxiety, and mood swings.

Dr Charles Gant (MD, Ph D) who wrote on the *Natural treatments for addictions*, compared the conventional approach to treatment of mental disorder with what he called the GANTS method, a method which recognises the role of Nutrition, Toxicity and Stress in the causation of mental symptoms. An important intervention step in these presentations is the examination of the nutritional and toxicity status of individuals. He concluded that "The number one health problem in the US and probably the entire world (alcoholism) is not being addressed in a rational, efficacious, scientific and safe manner. Until such scientific principles are brought to bear on the treatment of addictions it is unlikely and probably impossible for substantive improvements in care to occur".

Dr Stuart Shipko, MD (Psychiatry) and director of Panic Disorder Institute, I am sure, has saved a few hundred people at least from the debilitation and disability caused by psychiatric medication. He did this by simply examining the possibility that the patient could have been suffering from a medical disease. Apparently, the mental health system fails to detect one in six physical diseases causing a patient's mental disorder. This system also failed to detect more than half of the physical diseases that were exacerbating a patient's mental disorder. The importance of doing mandatory physical exams became glaringly evident through his fascinating lecture. This is so obvious, that we wonder why it is not being done. In the US health care system, which is totally run by private insurance, it is cheaper for the insurance companies to push psychiatry (with little or no testing) than go for expensive medical testing. By the time Dr Shipko went through the whole list of medical conditions that can

present as mental disorder, it was evident that minor to major mental ailments could well have organic causes that are misdiagnosed. Mercury poisoning (children's vaccines, dental fillings, effluents from coal fired plants, contaminated fish), other fungal, environmental, metal and gas poisoning, problems with adrenal and thyroid secretions, vitamin and other nutritional deficiencies were discussed. These lectures showed that with modernisation and mechanisation, as our food culture, eating habits and environment changes, we can expect a great impact on physical as well as our mental health. This seems such a self evident lesson, yet it needs to be taught.

Other fascinating presentations included Dr Gant's "Complementary solutions for children diagnosed with Attention Deficit Disorder", Dr Hyla Cass' "Nutritional and herbal remedies for depression" and Dr Cynthia Watson's "Role of Hormones in mood disturbances". The role of various essential fatty oils in child brain development, vitamin deficiency and mental disability in children, using common herbs for treatment of depression, hormonal treatment for dealing with reproductive health linked mental changes, etc. were some of the themes that were discussed in these presentations. The program ended with moving stories of recovery by using diverse, and for us, here, hitherto unexplored tools, for example, acupuncture and hormone treatment. The claim which Dan started out with, that a psychotropic drug is not a natural body nutrient, and let us use alternatives to drugs, was well validated through the program. For the first time, I met so many mental health professionals who were trying out a wide variety of solutions to address individual mental health needs, instead of just pushing prescriptions.

Thanks to Dan Stradford of Safe Harbor Project, LA, for quickly and steadily organising the required sponsorships which allowed me to travel. Thanks to Judy for sharing her home with me during my visit. Thanks to Dan and Betty for the many wonderful drives in LA during my visit. News about the program, and possibly, about purchasing recorded tapes of the lectures, may be obtained from Dan at www.alternativementalhealth.com

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Market *khabbar*

Economic Times (July 23rd, 2002) reported that Sun Pharma, a noted maker of psychoactive drugs in India, based in Gujarat, posted a net profit of Rs. 48.07 crore for the quarter ending July 30, 2002, showing an 18% increase over the same period for the last year.

The *Alliance for Human Research Protection* raised an alarm recently about the American Psychiatric Association's Annual Convention this year, which attracted around 14,000 doctors and 4,000 drug company representatives [only 30 per cent] as reported in *www.researchprotection.org/informail/0602.02.html*. Many incentives and freebies were offered to the experts (and sometimes refused) including airport pick-ups, free meals, bags, etc. An interesting marketing strategy employed by one drug company was the "virtual schizophrenic experience". Using virtual reality technology, viewers were given an opportunity to experience, *live,* what it means to live with schizophrenia. We wonder if this virtual reality tour included live experience of long term iatrogenic damage and disability caused by neuroleptics. Experts expressed reservations about maintaining professional dignity and objectivity against such aggressive marketing onslaught.

Among the by now notorious medical departments in Gujarat involved in administering Sodium Pentathol to the "Godhra accused", a well known psychiatry department from Vadodhara has been mentioned. The UN banned Sodium Pentathol in 1999, naming this procedure as one type of "torture". [*EGMail from South Asian Medical Ethics Group*.]

Dr. Reddy's showed 58.3% growth for fiscal year ending 2002. This is "predominantly due to blockbuster drug" Fluoxetine [famous as PROZAC], which contributed 3286 mn. rupees of a total profit of 15,578 mn. The net growth of Fluoxetine over last year is 24.9% The formulation showed a $13.5mn sales in the March quarter as against an expected $9mn., increasing the operating profit margin by 33.2% for the year. Not expecting another blockbuster in the near future, the company expects a 25% drop in profit, which they hope to make up by international dosage sales and bulk sales in the developed markets. ["*Take Stock, Vol 1 Iss 4, June 2002*]

disease is by choice

my mother had jungle rot
and my father, gangrene

I went mad

believing all my red corpuscles
were explosive devices
commanded by Mao
and one false step
would blow my mind

so I moved with crazy grace
the way the cripple
and the child dance

every movement a prayer

there were cures

my mother washed
her hands every two hours
for a year

and they cut off my father's toe

In mid dance
I was locked
in a room with no handle
on the door

you may ask
how I came to be here

it wasn't easy

Virginia Davis, Madness Network News, Winter 1979, Vol 5 (3)
In Bapu Archives, kindly donated by Mira Sadgopal.

Delhi psychiatrist challenges peers by contesting medical feasibility of ECT without anesthesia

Saarthak, a voluntary organization from New Delhi, has filed a petition in the Supreme Court (Civil writ petition No. 562). Their petition has asked the apex court to issue necessary directives to each state and union territory for complying with setting up statutory authorities under the Mental Health Act, 1987. The petition challenges the constitutionality of Section 81(2) of the Mental Health Act and says that this section is violative of human rights. This section provides that a mentally ill person may be used for the purposes of research, if such research is of direct benefit to him for purposes of diagnosis or treatment. It further provides that when such person is a voluntary patient, he may give his "valid" consent for such research or where such person is incompetent to give his consent, by reason of minority or otherwise, the guardian or other person competent to give consent on his behalf can give consent in writing for such research. The petition argues the inadvisability and "barbarity" of ECT without anesthesia and highlights the risks involved (bone fractures and other bodily injuries; problems with ECT in general, such as confusion, loss of memory and back problems). While the petition admits that modified ECT may be beneficial, it talks about prescribed guidelines even in such cases. The petition prays for avoidance of physical restraint and confinement, except under "extreme" circumstances, where guidelines would specify assessment of risk to self and others. Even when used, such practice, it is urged, should not be an indefinite one. 6 hours is being suggested as acceptable period for review, which would be done by a Medical Board. The petition appeals for the prohibition on chains and persuades the use of alternatives such as cotton bandages or sedatives in extreme cases. The petition persuades the provision of "psychiatric therapy" [sic!] and proper facilities for rehabilitative counseling, and quarter way homes. Patients should be informed about the legal aid services provided for by statute.

(*Papers shared with us by Mr SK Ravi of Action Aid India, New Delhi)*

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Mental health professional's response

"In Gujarat, mental health professionals have been working with violence victims in government hospitals and relief camps. However, the response has been feeble when compared to the Bhuj earthquake. The most important reason for this is the fear and uncertainty of the situation. Second, the sanction of violence by a large majority has affected mental health professionals as well. … Gujarat needs a long-term plan for community based psychosocial intervention using volunteers. Every victim has a right to mental health relief for a reasonable period, provided by the State. Research or assessments must include an action component; victims should not be viewed as a laboratory. Counsellors must plan to work on long term conflict resolution and move to the centre of the disaster zone, not hide in the periphery. … In Gujarat, the mental health fraternity was silent fearing the disruption of "therapeutic neutrality". This is a denial of professional responsibility. Mental health professionals need not be sloganeers, but they must raise sane voices during difficult times. … [O]n the whole, silence has transformed the profession's empathy into apathy. This collective silence must be broken with concerted action towards healing and prevention".

Dr Harish Shetty, Psychiatrist, MAITRI, Mumbai in *Issues in Medical Ethics*, Vol. 10(3), July-September 2002.

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Saying thanks…

To Jos Brand, a Development Consultant from Holland, who kindly donated Rs. 1000/= to *Aaina*, because he "liked it very much"!

Thanks, Jos!

Who is a mentally healthy woman: A feminist therapist answers

A mentally healthy woman is one who

- Values herself as an individual and as a female rather than depreciating herself as a woman
- Chooses behaviours according to their suitability and to the situation, deliberately resisting conforming to female gender stereotypes and certainly not conforming to them unwittingly
- Consistently tends towards emotional, social and economic self-sufficiency, striving for separateness and autonomy before seeking interdependence
- Blends autonomy with interdependence in the form of a selected number of deep relationships with others in personal and social activities
- Appreciates differences as much as similarities, preferring variety in herself and others to stereotypes
- Does not victimise herself, does not let herself be victimised, and does not present herself as a victim
- Enjoys the power of her emotions and her self, and displays this power through vivacity and energy
- Orients herself toward reality and realism, avoiding overreaction in favour of accepting herself, others and the world for what they are
- Takes risks and extends herself without placing too much emphasis on either success or failure

From *Arrows for Change*, "Women's Well-being: Reframing Mental Health" Vol. 7, No. 3, 2001 (www.arrow.org.my)

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The gains from the recent SC orders are meagre, says disability advocate

An interview with Prof Amita Dhanda
[NALSAR, Hyderabad]

What happened after Erwadi with respect to the supreme court?

Dr Dhanda- The SC took *suo moto* notice of the Erwadi incident. On its own, it asked the chief secretary of the TN government to file an affidavit reporting exactly what happened. They came to know of cases where persons labeled mentally ill were being kept in very inhuman conditions in other states also. So they asked all states to file affidavits. Saarthak, an NGO, also filed a petition, not raising issues such as Erwadi, but raising the question of giving unmodified ECT to patients. It also raised questions relating to psychiatric research being carried out which are not directly benefiting the patient. There is a provision in the mental health Act that allows this. The MHA says that you can carry out experimental or beneficial research on a person with mental illness with her or his consent. But equally, you can also do it without the consent whether the research is directly beneficial to the individual or not. The Saarthak petition is asking for removal of this provision altogether as unconstitutional. About ECT, they are saying that unmodified ECT should be banned, that the persons who administer such ECT should be criminally prosecuted and that a committee of NGO representative, social worker and a psychiatrist should regulate ECT practice. Saarthak has also asked for the implementation of the statutory provisions of the MHA, such as the State Mental Health Authority, the licensing authority, etc.

This intervention by the SC is yet another one in a long line of such interventions. Does this case have implications that are far-reaching or different?

To the best of my knowledge, regulation of ECT as well as consent in experimental research are brought before the SC for the first time. The Goa bench of the Bombay High court challenged unmodified ECT use, ruling that such like ECT cannot be administered. The Saarthak challenge is to the MHA provision that research *can* happen whether beneficial to the patient or not; and whether he or she gives consent or not. They are saying that using surrogate consent is unconstitutional. There are indeed problems with these provisions, but a number of people are saying that maybe you should have a closer look before writing off the whole thing as unconstitutional. If the provision was struck off altogether, it would discourage mental health research which in the long term may work against the interests of persons with mental illness. The petition could have suggested the setting up of ethics committees on a mandatory basis or a more public centric process of scrutinizing research. There is a problem with surrogate consent. The problem is that there is a thin line between consent with understanding and consent with undue influence. But rendering the provision for conducting research altogether as unconstitutional would prohibit even such research where valid patient consent is there. What if a patient or a class of patients want some research to be conducted, which they feel is beneficial to them? The petitioner could have asked the court to read up that provision in more plausible ways, which will limit the scope of surrogate consent and give greater validity for patient consent. This way, both the interests of the patient— autonomy as well as the right to good quality care—could have been upheld. If you were to strike it down today, then tomorrow you will have to start the process all over again because of the feeling that law should permit such research, which is in the interest of the patient.

Is there any authority, which stipulates ethics committees?

Not the MHA. The ICMR does require that ethics committees should review all medical research proposals. Institutions in India, which undertake medical research, do have ethics committees with external members. Psychiatric research proposals also have to

... Continued on Page 11

go through those ethics committees. But the statute does not speak about it. In the case of persons diagnosed with a mental illness, it may be wise to have a statutory protection. Such a ruling by the SC would also give legal validity to ethics committees in general, giving such committees more teeth.

What are the other contentions in the Saarthak petition?

The petition is looking at the whole issue of the rights of persons with mental illness in a very limited manner, where you are asking for nothing more than the setting up of so many statutory authorities. Setting up of authorities, generally speaking, becomes like largesse giving of the State. It does not really impact upon a person with mental illness as he or she does not have a say in the matter of who you are putting into the board of visitors, what kind of people are coming into the state mental health authority (SMHA), etc. The SMHA is only a recommendatory body. The only thing is that every kind of service including prisons and jails are within the purview of the SMHA. The rest of the statute only speaks about psychiatric hospitals and nursing homes, and does not speak of any other mental health facility. Psychiatric departments in general hospitals have been explicitly excluded. The jurisdiction of the SMHA is much wider, but it is purely recommendatory. So, if the state is passive about the recommendations, the Act does nothing to protect.

You are saying that the suo moto petition is very much within the MHA framework, which is anyway not safeguarding patient interests in any way?

Absolutely, that is what I am saying. What we need to appreciate is, what exactly is the MHA doing. As a statute, if it is only regulating entry and exit from a mental hospital, then the statute has not done anything much. These are questions, which possibly can be raised in the petition, but the petition is primarily stressing on implementation aspects of the MHA. Suppose all the authorities were in place and functioning effectively, would we have a rights sensitive regime for persons with mental illness? Perhaps not, and therein lies our anxiety.

In response to Erwadi, the SC suo moto action as well as the petitioner has assumed that if the MHA had been effectively implemented, there would have been no problems and all human rights would have been fully restored. Obviously, that is not a correct assumption. Could it have been possible for some of the Erwadi residents to make a complaint to some authority about their neglect or overall deprivation? Was there some tribunal or authority given by the MHA who they could have approached? Is there a complaints procedure in the MHA?

No, there is nothing. What they could have done is just to file a writ petition in the High Court with help from state legal aid authorities. But if you were chained to your cot, how would you do that? In other countries you would have mental health provisions and processes of compulsory review. The SMHA is not somebody you can complain to. The board of visitors will only go to the government mental hospital or the licensed psychiatric facilities. Erwadi was not a licensed facility. There was a whole lot of persons who were illegally detained. The court is only seeing it as people who are found in incorrect sites, of wrongful confinement. The court is saying that, here is a person with mental illness, the correct place for them to be is in the mental hospital, not in the community. Affidavits from every state say that they are not keeping people in chains as in Erwadi. But again and again the SC has been encountering data showing otherwise. The only immediate solution they found was to send people to the mental hospital. Once you get in there, a whole range of deprivations starts to happen, including social ostracism. The court has not addressed these issues in this case, nor does the MHA. There is a necessity for legal provisions regarding ways of getting recovered people back into the communities and what to do about errant families. These issues have been repeatedly coming up right from the Shahadara petition to Ranchi and so on, this is not the first time. Every time the court looks at it as if something new has happened, and has not really tried to work out the directives. If you want the state money to be invested in mental health, then you have to say, create and

diversify the mental health services, facilitate rehabilitation and restore civil status… this is an absolute basic right. These questions are absent. The full implementation of MHA is not going to be a solution.

In the area of health, policy comes first and law comes later. In fact, in public health, the problem is that you do not have any legislation backing policy. There are problems with health policies, but at least there are people who are looking at what is the policy. In mental health, the reverse seems to be happening. Every few years, you have a SC case which triggers off a debate about MH and law, but hardly any kind of discussion on the policy front. How do we explain this?

The care and treatment for persons with mental illness from the 19th century onwards has been institutionalized care. The abuse happening within private institutions inspired the birth of a law. Law came in as a positive measure, when people were saying that they wanted their own practice to be regulated. They wanted that kind of a shackle. Then community care came in but even then mental health care was the only one that continued to be regulated by the law. In the 1980s you had an NMHP (National Mental Health Program) coming, but this did not in any way engage with the legal regime. Somewhere there was the anxiety that they had engaged earlier and failed. There was the fear that possibly they might also come within the ambit of the law, and that, they did not want. That is my reading of it. Subsequently because of this fear, there was some kind of a policy happening, some initiatives carried momentum. But you cannot possibly construct a mental health policy without engagement with the law. Also, lot of these discussions happened only within psychiatric circles. The court was constantly asking psychiatrists to help it to adjudge 'insanity'. This is where the professionals have come in always. Otherwise they have in recent times always sidestepped the law. Now, for the first time a psychiatrist is asking the supreme court to rule on professional regulation issues and the medical feasibility of a particular practice (ECT). This is a positive development.

Is it correct to say that the MHA does not tell you what should be allowed to happen within licensed facilities: whether, for example, they should do family therapy, psycho therapy, what kind of treatment you should get, what should be the quality of that treatment, whether there should be a rehabilitation program, whether there should be rationally prescribed drugs, regulation of ECT procedure, an updated essential drugs list? Is the right to rehabilitation as a fundamental right built into the MHA?

No, it is not. The minimum standards of care mentioned therein are all quantitative, such as ratios of doctor/nurse/patient, physical infrastructure. There is no mention at all about the quality of care. It is not in the Act nor is it in the rules. The Act is basically about entry and exit from mental hospitals, which was there in the Lunacy Act anyway. So, if in 2001 or in 2002, you are filing a petition in the apex court, and you are only asking for the implementation of the Act, and actually believe that the implementation of the Act is going to make for a better deal for persons with mental illness, you are living in a world of fancy.

The critical issues about the quality of care and rehabilitation, do they need to come into the law?

There is a need for placing general principles of care and treatment within the law, and to recognize that the psychiatric patient needs an active protection, but the content may not find a place there.

Do you see anything positive about these interventions?

For the first time, nearly every one, lay persons as well as professionals have woken up to the tragedy evoked by Erwadi, to the fact that a certain segment of society is living under such conditions and are treated like that…

- Interview by Bhargavi Davar

Dr. Dhanda can be contacted at amitadhanda@rediffmail.com

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The WHO's global initiatives in mental health are not "rights sensitive" says UN accredited NGO

The buzz in the mental health world these days is the WHO's world initiatives in mental health. Following the release of the World Health Report, 2001, the WHO has been putting together advisory consultations in many countries around the world, in order to come up with "modules" or manuals that will aid governments in mental health sector improvements. Several topics are being planned as a part of these manuals. This is a more proactive role that we see of the WHO in recent times, which has hitherto played an almost passive role with respect to mental health globally.

David Oaks, chief of Support Coalition International, a world network of over a 100 grassroots organisations fighting for human rights within the mental health system, asks a pertinent question about this initiative. For years, the WHO multi-centric outcome studies have highlighted the triumph of traditional societies, including India, in providing the social conditions required for a better prognosis for persons diagnosed with mental illness. Apparently, there is something about such societies, whether nature or nurture, which is more healing for the persons so diagnosed. Why is it that this very same organisation is now creating "templates" for these very same societies based on a completely alien, western model, which anyway, as we all know, has not done all that well in comparison? When asked by the WHO to comment upon the "modules", SCI, the only UN accredited NGO in mental health worldwide, has recommended that the manuals be put on hold until the WHO adequately addresses issues of human rights and empowerment within the mental health service system. The charge is that while the WHO manuals make constant reference to "human rights", the implementation part is not spelled out. "More of the same", without adequate protection of human rights, is worse than doing nothing, according to SCI. While the WHO manuals (apparently) talk about advocacy positions, in the actual consultative processes, they have not involved any leadership from consumer organisations and support groups. Mostly, the consultants have been the psychiatric professionals only. With respect to India, too, this has been the case.

[SCI network mail. For more details contact SCI at www.mindfreedom.org].

On paranoia- A professional crisis or a deep philosophical dilemma?

"Psychologists feel that they have learned a great deal about this form of emotional disturbance, merely by following paranoids around. The main thing they claim to have learned is that paranoids suffer from the delusion that someone is following them. This, of course, is non-sense. The people followed by psychologists don't suffer from a delusion that they are being followed: They really are being followed – by the psychologists, who mistak-enly diagnose them as paranoid because they exhibit symp-toms of imagining they are being followed. Except, as previously explained, they don't just imagine it. When they aren't being followed, they don't have the symptom. Only, the psychologists never see them when they aren't being followed." *(From the 'Mad Weirdo Watcher's Guide', 1982)*

Drug Warning

Bristol GlaxoSmithKline has been now forced to admit that paroxetine, a widely prescribed antidepressant and the company's best selling drug, can cause severe withdrawal symptoms when stopped. For many years, the drug has been advertised as "non-habit forming". It roped in about 10% of the company's overall revenue. The FDA has published a new product warning about the drug, and the International Federation of Pharmaceutical Manufacturers Associations declared the company guilty of misleading the public about paroxetine. The drug can cause intolerable withdrawal symptoms, such as bad dreams, paraesthesia, dizziness, agitation, sweating, and nausea. Paroxetine apparently has one of the highest rates of side effects among all antidepressants. [*Source: www.psychminded.co.uk/news/0302/withdrawal%201.htm*]

Report of a Visit - Excerpts

By Anil Vartak, Pune

"Self-help support" in groups for persons suffering from mental illness and their caregivers is relatively a new concept in India. We have been working as a self-help support group (*Ekalavya*) in Pune, India for last three years since 1997. However, we have had a feeling that our quality of work was not up to the mark for the following reasons: a) The number of members was not increasing b) We were lacking a neatly defined structure c) Some members as well as some professionals were skeptical about usefulness of a support group. These problems made us realize the need for a more organized approach for future growth.

Last year, as Secretary of the Pune chapter of the Schizophrenia Awareness Association, I was extended an invitation to visit some mental health organizations in the USA. I prepared for this trip both individually (through an introductory correspondence course for mental health facilitators) and within the Eklavya group through discussion. The immediate objectives of my trip were to help us redefine our aims and objectives, to enable us to conduct our group activities in a more skillful way, and to assist us in designing and producing educational materials to support our activity. The most critical area, it seemed to us, was defining the procedure for group meetings. We were learning by trial and error, but that has its risks. We felt the need to learn from other groups who were more experienced and working successfully.

I reached New York on 29th May and left from New York on 17th July. During my stay, I visited and interacted with Recovery, Inc. (Columbia Station, Ohio); Schizophrenics Anonymous (East Lansing, Michigan); NAMI - National Alliance for the Mentally Ill (Annual Convention, Washington DC); Exhibition: The Brain (by Pfizer, at Smithsonian Museum, Wash. D.C.); New Jersey Self-Help Clearing House - NJSHCH (Danville, New Jersey); Mental Health Recovery (Brattleboro, Vermont)

"Recovery" is a nationwide self-help support group network founded in Chicago in 1937 by Dr. Abraham Low, a neuro-psychiatrist. There are over 700 Recovery groups active in the USA and some in other countries. The organization's members believe that Dr. Low's work is authoritative. Any other approach than his is not part of Recovery meeting procedure. The weekly meetings typically follow a standard format- a reading from one of Dr. Low's books, without discussion; a "Panel Example" by one person in the group; "Spotting" of "Symptoms"... by other members; "Self Endorsement" by the person who gave the example; a question-answer period between members and group leader; a "mutual aid" and refreshment session.

The "Panel Example" is the core part of a Recovery meeting. Any group member can volunteer to give an example from her or his daily experience. The example is treated in 4 stages, description of event, recalling discomfort, self-analysis, using Recovery principles to see things differently. Once the example is given, the other members comment in a specific pattern. Nobody is to criticize or advise or give suggestions, but just to highlight positive points in the example. This "spotting" helps in seeing the same example from different perspectives. Finally, the example-giver endorses himself / herself for the effort and achievement.

Schizophrenics Anonymous [SA] is a self-help support network for persons suffering from schizophrenia and related disorders. Ms. Joanne Verbanic who suffered from this illness and experienced the agony and neglect of persons living with schizophrenia founded it in 1985. After initial trials and errors the group worked out a definitive Six-Step Program towards recovery, offered weekly. The 6 Steps of SA consist of the following- I SURRENDER (I need help), I CHOOSE (to be well), I BELIEVE (that I have great inner resources),

I FORGIVE (mistakes of the past), I UNDERSTAND (that self-defeating thinking contributes to my problems) and I DECIDE (to turn to a higher power, "God"). God can be interpreted in various personal ways. SA operates on the principle that sharing of experience offers ventilation of feelings, elicits support from fellow members and helps one to gain insight in one's own problem. Planned replication of the initial successful attempt is an important feature of SA's growth.

NAMI (National Alliance for the Mentally Ill) is a national organization established by and for caregivers of persons suffering from serious mental disorders. Along with any sufferer, the caregivers also pass through emotional turmoil, agony. The fluctuations in the state of their loved ones literally break them, and they get exhausted in the fight to sustain. On top of it, in this difficult journey they face isolation, loneliness and lack of skills to deal with the problem. The organization has a variety of activities to their credit – self-help, dissemination of information, educating caregivers, imparting skills to caregivers, running a newsletter, legislative advocacy work and so on. I attended NAMI's five-day annual convention at Washington, D.C., where more than 1000 members took part. NAMI's Family-to-Family Program is running successfully, through which it tries to impart information and skills to families.

Even though support from a self-help group can help it's members immensely, being member-focused and local, knowledge about its location and importance hardly reaches other people - prospective members, professionals and the public in general. Clearinghouses such as the New Jersey Self-Help Clearinghouse – (NJSHCH) help to fill these lacunae, and there is one in most of the States of the USA. NJSHCH was established in 1981 with the objective of increasing awareness, utilization, development and understanding of self-help groups in order to reduce suffering and isolation. It has helped develop more than 1000 new groups, and receives thousands of calls a year asking for information. It provides general information and guidance related to the locality of groups. For this they provide toll-free telephone facility, maintain a state directory of self-help groups, answer e-mail and maintain a website.

Self-help Support as a philosophy seems to be well settled in the USA. Different kinds of self-help groups and networks are working for persons suffering from Mental Illness and for their caregivers. If a support group has a well defined philosophy, objectives, a neat structure and methodology of running the group, it gives identity, security and clear understanding to each member. In the USA substantial institutional care is available to persons with severe disability. Persons who do not have a severe disability usually participate in the support groups. In India, however, persons with moderate or severe disability attend our groups, adding challenge to group dynamics. While institutional care facilities are limited in India, families generally care for their own members and are ready to devote time and resources. This social feature should be optimally utilized. However, to support such families, there is a need for training about skills of care giving. From my experience in self-help work, if the group wants to function effectively, it should have some firm direction to help the members find solutions rather than simply narrating their experiences. Considering the socio-cultural diversities of India, suitable methodology and philosophy for self-help group building need to be developed. Social aspirations need to be given importance, but importance should not be given to any particular religion or belief system. Rather the working of the group should be based on the psychological dynamics of human beings.

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Picnic Planning

Eric Shapiro

Since I live right off of Hollywood Boulevard, I'll describe my experience with obsessive-compulsive disorder by way of a movie metaphor. Most of us, I am sure, have seen Stanley Kubrick's adaptation of "The Shining". Those of us who have seen it probably remember those images of the two little girls. At different points in the movie, when the audience least expects it, a terrifying shot of two ghost children flashes on the screen, just long enough to give any well-adjusted person the creeps. I have often spoken of this image when describing my obsessive thoughts. It is as though unwanted frames have been spliced into the movie of my mind. I am going about my day, thinking about safe, rational, and largely acceptable things, when suddenly a flash of something – be it visual or in linguistic form – springs out from my stream of consciousness.

These images began occurring in 1996, the year before I went to college. The accumulating pressures of having to graduate high school and move on were taking their toll. I didn't know what to call these images, but I knew I was off balance. The content was far more troubling than two little ghost children. I don't want to upset you with specifics, but, let me encourage you to imagine the most depraved, amoral and vicious thought you can conjure up. Travel as far from the realm of mainstream appropriateness as possible, then keep going…

The origin of these intrusive thoughts was unknown. Sure, I was stressed out due to finishing high school, but then again so were my friends. From my vantage point, my friends did not appear to have the Marquis de Sade revising *their* brain patterns. Inevitably, my central consciousness, the ruling element of my personality, my "self", became very concerned. You can't last very long having these images without eventually questioning your own morality. A catchy phrase I came up with around this time was "The reflecting loop". To me, the mind is like a reflecting loop: always watching itself, and, moreover, watching itself watch itself, round and round. This natural process became very strenuous for me as I tracked these images around my own head.

But I said to myself, "Wait until college. These symptoms are surely transitional, so let the transition run its course". By my fourth month in college I was having upwards of five intrusive images per minute. Every minute. Every hour. Every day. Now—being a relative stranger to the concept of a mental disorder, it was hard for me to adjust to the idea of visiting a psychologist. At some level, until you have actually done it, the idea of seeking counseling is dreadfully symbolic. I felt like I was throwing in the towel somehow—How could this be me, making this appointment? Unfortunately, I had no choice.

I saw upwards of a dozen professionals while trying to overcome this condition, so let me just freefall through all my attempts at getting better. Names will be withheld:

- The first psychologist I saw was in Boston, where I went to school. This guy was masterful. Harvard-educated, eloquent, sympathetic, he had a serviceable and satisfying answer for every question I threw at him, every moral riddle I came up with. Unfortunately, his patient list was full, so I only saw him twice. So began an arduous journey that lasted about ten months.

- The second psychologist, whom I was referred to by the first psychologist, was slightly less worthy of acclaim. Before I go on, I should note that I don't hold any schools of healing in higher regard than any other schools. This is purely my own experience. This particular psychologist was convinced (*I mean, CONVINCED!)* that the entire, thorough, all-encompassing, undeniable, indisputable cause of my obsessive thoughts was something that had happened to me at the age of two. As I had told him, I had a hernia operation as a baby, and afterwards was unable to drink milk. The doctors kept my bottle away from me, and, as my mother would inform me much later in life, I freaked. I cried, I screamed—Indeed, I did none of the things that babies do! Or, wait. Maybe that hernia incident had absolutely no link to my current predicament whatsoever? So, I did the appropriate thing: I hit the doctor up for a half dozen absentee slips so I could miss a few classes and I never called him again.

➢ Ending my obsessions was becoming an obsession of its own. So I bit the bullet and looked into psycho-pharmaceuticals. Got myself a psychiatrist, who introduced me to the less popular first—a cousin of Prozac, Fluvoxomine, LUVOX. I had a good amount of hope, but there were some catches. We all know the drill: It would take upto three months for LUVOX to become effective, and if not effective, it would take another three months to wean myself off. Also, there would be endless experimentation to determine an adequate dosage. And there was only a 60 percent chance of success. And, oh, I might not feel any emotions for a long time… sounded like a good deal to me! LUVOX was a strange guest. It is tempting, just for the fun of it, to say the drug was an outright failure, but the failure was not outright. It sort of quieted my head down. You know, sort of like turning on the radio quiets the television down.

➢ While I was waiting for LUVOX to kick in, I tried behaviour-response therapy. Around the time I went in for that, I was having obsessive thoughts and images of an excessively philosophical nature. Basically worrying about the universe at every turn. At the end of one session, I said to the doctor, "I have been thinking a lot about my hands… Like, how do I move them? I mean, I know how to move them, but how do I know how to know?" The doctor thought about it for a second, looked me in the eye, and said, "That should be all for today, Eric. I will see you next week".

➢ Homeopathy came next. I was still on LUVOX, so by this point, I had a new fear that - by the time I was cured, I would be unable to pinpoint what had cured me. Homeopathy, like LUVOX, sort of took the edge off. Things were a little slower, a little more comfortable. But no fireworks yet. I knew in my heart that if I had felt fine before these symptoms, I could feel fine again. Completely fine, without compromise. So, with my family's vital support, I continued my trek.

Getting healed is like falling in love. A whole series of disastrous encounters can occur before you find "the one". I will share with you the name of one professional I saw, because it would be a disservice to him if I didn't:

➢ Everything I am saying here is true. Randy Sutton stands about six foot four. He has a handle bar mustache. He lives in a house in the New Jersey Wilderness, right near where I grew up, and he built the house with his own two hands. In the basement of the house, he heals people… with those hands. Now don't worry, I am not about to trail off into some new age rant—I was skeptical about seeing a man like this. He had befriended my mother somehow, and supposedly he was going to balance my body with the use of energy. Clearly, this was a colossal waste of time. Anybody who would benefit from that kind of treatment has got to be a flake!

Well, I come before you as a certified flake. With an inventive combination of reflexology, acupressure, herbs, and verbal encouragement, Randy carried me home. Within two months, which is less time than it took for me to feel the initial effects of LUVOX, I felt adequate. The frequency of the vicious thoughts was lessening. My tone of being was lighter. I found that the occasional hour would pass without my even thinking about OCD. I have since maintained a balanced state with the aid of acupuncture, which I have found accesses the same energies as Randy's method, but with more durable results. With Randy, I had to go in weekly. With acupuncture, I go every three or four months. I have since written a fictional book on the topic of mental disorders, a triumph which would have been unthinkable had I still been in the clutch of the disorder.

Does this mean I am all fixed up, one hundred percent, no more wrinkles? Needless to say, it does not, but most of the time I feel eighty to ninety percent better than I did that first year. It is a wonderful gift to have a mind that you are in control of. No approach is not worth trying. If you limit the amount of avenues you are willing to travel, you will probably never reach your destination. But with risk and resourcefulness, the odds will fall well in your favour.

Eric Shapiro is the author of SHORT OF A PICNIC, due in September from Be-Mused Publications. He can be contacted at Shortofapicnic@aol.com

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WP(Civil) No.334/2001 in the Supreme Court of India, re: Death of 25 chained inmates in TN & WP(C) No. 562/2001 — Saarthak Vs. Union of India & others

This case was called for hearing on 12/04/2002 before Hon'ble Justices MB Shah, Bisheshwar Prasad Singh and HK Sema. Counsels were heard from Tamil Nadu, Rajasthan, Karnataka, Pondicherry, Nagaland, Sikkim, Chhatisgarh, Andhra, Arunachal Pradesh, Manipur, Uttranchal, J&K, Goa, UP, Tripura, Assam, WB, Meghalaya, Rajasthan, Gujarat, Punjab, Haryana, MP, Maharashtra, Jharkhand, UT of Chandigarh, Orissa, Karnataka, HP. UPON hearing counsels the Court made the following ORDER-

"In continuation of our order dated 5th February, 2002 and considering various provisions of the Mental Health Act, 1987, ... it is directed as under:

"1. Every State and Union Territory (UT) shall undertake a comprehensive Need Assessment survey and file the Report thereof on the following aspects: (a) Estimated availability of Mental Health Resource personnel in the State, including psychiatrists, psychologists, psychiatric social workers and psychiatric nurses in both the public and private (licensed) sector; (b) Type of Mental Health Delivery System available in the State, including the available bed strength, outpatient services and rehabilitation services in the public and private (licensed) sector; (c) An estimate of the Mental Health Services (including personnel and facilities) that would be required having regard to the population of the State and the incidence of mental illness.

"2. The Chief Secretary of each State and Administrator / Commissioner of every UT shall file an Affidavit stating clearly: i) Whether any minimum standards have been prescribed for licensing of Mental Health Institutions in the State/UT and ... full details thereof; ii) Whether each of the existing registered Mental Health Institutions ... meet such minimum prescribed standards ... and if not, what steps have been taken to ensure compliance ... iii) How many unregistered bodies... purporting to offer psychiatric/ mental health care exist ...and whether any of them comply with minimum standards ... if not, whether steps have been taken to close down the same; iv) Whether any mentally challenged person has been found to be chained ... v) Conclusions on the basis of the Need assessment Survey undertaken in terms of direction (1) above. ... Each affidavit must specifically and comprehensively deal with each of the queries above.

"3. The Report of Need Assessment Survey and Affidavit as set out in Directions (1) and (2) above shall be submitted to the Health Secretary, ... latest by Ist July, 2002. The Health Secretary... shall thereafter compile and collate the information and present the same ... to this Court along with his conclusions. ...The Chief Secretaries of all States and Commissioners of all UTs who fail to file such Affidavit ... shall have to personally remain present on the next date of hearing and explain the default.

"4. Union of India is directed a) To frame a Policy and initiate steps for establishment of at least one Central Government run Mental Health Hospital in each State ...b) To examine the feasibility of formulating uniform rules regarding standard of services for both public and private sector Mental Health Institutes; c) To constitute a committee to give recommendations on the issue of care of mentally challenged persons who have no immediate relatives or who have been abandoned by relatives; d) To frame norms for Non-Government Organisations working in the field of Mental Health and to ensure that the services rendered by them are supervised by qualified/ trained persons. ...

"6. LEGAL AID- Under ... (MHA), a patient is required to apply to the Magistrate in order to be discharged. The procedure ... causes difficulties to the patients ...as many patients may not be in a position to

make the requisite applications before a Magistrate, nor would they be aware of their rights, and the procedure to seek discharge. ... [T]wo members of the Legal Aid Board of each State be appointed to make monthly visit to such Institutions... to assist the patients and their relatives in applying for discharge from the Institutions if they have fully recovered, and do not require institutional assistance...

"7. 1. Patients and their guardians shall be explained their rights by a team of 2 members of the Legal Aid and a Judicial Officer, under the Mental Health Act, in a language known to them, at the time of the admission to any Institute. They should also be informed whom to approach in case their rights are being infringed.

"2. ... A Board of Visitors must be formed by the State Mental Health Authority in every State within a time bound period, and a compliance report be filed to this Court. The Board of Visitors shall be required to visit every State or Private Institution for the time being at least once every month. The membership of the Board of Visitors ... includes, a) Not less than 5 members b) At least one Psychiatrist c) Two Social Workers preferably with knowledge of the issues in the hospital and may be from the NGO Sector. d) Head of Medical Services or their nominees (preferably a Psychiatrist) as ex-officio member of Board of Visitors in the State; The Board of Visitors should also include 1. The Additional District Judge, and/or Chief Judicial Magistrate, and / or the President of the Bar Association of the Area; 2. State Disability Commissioner or his/her nominee. A monthly record of visits of the Board of Visitors and a quarterly report should be filed with the State Mental Health Authority.
…

"8. A Scheme may be envisaged for re-habilitation process for those who are not having any backing or lack of support in the community. The Scheme may be on the basis of Quarter-way homes (Supported Shared Home Like Accommodation) for all patients ready to be discharged, but are not being discharged due to family not taking them back, or lack of support in the community, should be placed in a home like accommodation created on the hospital campus itself. This accommodation could be an existing ward converted to have a home like environment, with patients being taught housekeeping skills, cooking, shopping and also encouraged to take up responsibilities in the hospital for which they should be paid for and then gradually encouraged to go to the community for work.

"Learned Amicus Curiae Dr. Singhvi rightly submitted that if any suggestions are made by any interested parties, the same may be submitted through the Mr. Pranab Kumar Mullick, Advocate (Amicus Curiae) and we order accordingly."

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images

Fear

…
They are soon to descend upon me
I can see the shine of the knife
in their eyes
I know a stream of warm blood
will rise from my heart.

I do not fear death
I know
it is too simple an event
hidden in my cradle
the moment I was born…

I fear you
with calm eyes
who are all watching me
and my desperate steps
to save my life

Simon Marti from Thane, Maharashtra

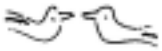
Those dreams of hers...

That same girl of the city,
who was busy and fine
has changed a lot
along with time

Her dreams have also changed
along with her ways
those hours she spent dreaming,
those nights, those days

Today in her room sitting
she remembers every past moment
every little time she spent
thinking of being competent

She had decided to meet him first
then, friends to make,
then with all her gratitude
his lovely hand to shake ...



But now those dreams
were no more young
They had miserably
to the ground, flung

Dreams as they were
not reality, but dreams,
for now in the night,
she howls and screams

Her dreams have now just shattered
She is one of the women, badly battered

Ms Lara Jesani, Mumbai

Aaina, a networking and opinion sharing newsletter in mental health, is for private circulation only. It is sponsored by Bapu Trust for Research on Mind & Discourse, an organisation committed to mental health literacy and advocacy. The views expressed in the newsletter are however not those of the organization.