

# *aaina*

a mental health advocacy newsletter

Vol. 1 No. 3

November 2001

## Editorial

Two major events have happened in the last quarter, requiring our immediate response and energies.

On August 6<sup>th</sup>, 28 people labelled as ‘mentally ill’ in Badhusa mental home in Erwadi Dargah, Ramanathapuram, Tamil Nadu, perished in a fire. No one was questioned, no one arrested and none punished. In this issue we remember the victims of this ‘inhuman holocaust’ perpetrated by private trade and brokering of mental patients.

The Erwadi holocaust caused a lot of public outrage. For the first time, newspapers, professionals, NGOs, the state government, the Supreme Court, the National Human Rights Commission, human rights activists and lawyers, all made immediate and heart felt responses. However, two months later, in October as we write this editorial, the Erwadi holocaust, and the multiple questions that it raised, is a distant memory- a forgettable nightmare.

*Aaina* will again and again remember the many human lives sacrificed and wilfully wasted in Erwadi, and in many places *like* Erwadi. We’ll not allow ourselves to forget. When we remember Erwadi, we also remember our own agency in excluding people amidst us with the label of ‘mentally ill’. We remember a friend, a cousin, an aunt, an old uncle, who we have not stopped from being forcibly institutionalised. We remember a wandering lunatic, a voluntary boarder, a Cell-XYZ patient, a substance addict, who died due to neglect- dehydration, gastroenteritis, diarrhoea or badly administered ECT.

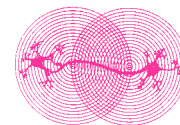
Now the second event- On 4<sup>th</sup> of October, Malati Ranade the first psychiatric social worker to be appointed to Yerawada Mental Hospital, Pune, passed away. For us, she is an icon in mental health activism and we remember her. We remember her, not as a saviour, but as a survivor... someone who doggedly survived the oppressive conditions of the asylum where she worked and who fought it to the very end in the name of humanity.

We dedicate this issue of ‘*aaina*’, then, to the inmates of Erwadi, to Ms Malati Ranade and to the thousands of victims and survivors of mental institutions in India, both private and public, for whom no memorial has been built, no songs have been sung. No one recorded their oral histories, no poem was ever written for them and none lit a candle in remembrance. Thousands have died, forgotten and alone, on the hard cold floor, unclothed and uncleaned, lice in hair for company, with not a warming touch for years. For *aaina*, August 6<sup>th</sup> is a day of remembrance and of grief.

## surviving institutional care

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**bapu**

Trust  
for  
Research  
on  
Mind  
and  
Discourse

Dr Amita Dhanda

Persons kept in chains without authority of law allegedly ‘mentally ill’ – were burnt to death. The situation was within the knowledge of a number of public officials and the National Human Rights Commission, yet no steps were taken to remedy it. Evidently cruelty and exploitation if interlaced with religion have to be overlooked and condoned.

The question however is: what can concerned citizens do when Erwadi-like situations come to the fore. Amongst the various investigations such a general query requires, one, which necessarily needs to be raised relates to the legal management of the issue. Thus we need to know how does law deal with this situation and what remedies if any are provided under it.

The Mental Health Act of 1987, a special legislation dealing with the institutional care and treatment of persons with mental illness, requires that a license be obtained before a psychiatric hospital or nursing home is established. Any person who maintains a psychiatric hospital or nursing home in contravention of the Mental Health Act shall in the first instance be punishable with imprisonment for a term, which may extend to three months or with fine up to Rs. 200/- or with both. Second and subsequent offences are punishable with imprisonment for a term which may extend to six months or with fine which may extend to Rs.1,000/- or with both. This section even with its limited sanctions does not allow for citizen enforcement as no court shall allow the prosecution of this offence unless the previous sanction of the licensing authority has been obtained.

(continued on page 3..)

**Editorial Team**

Bhargavi Davar  
Sadhana Natu  
Radhika Kulkarni  
V. Radhika  
Soumitra Pathare

**Design and Layout**

Anand Pawar

**Printing**

Anita Printers, Pune

**Contact Address**

7, Krishna House  
Fatima nagar  
Pune- 411 013  
Tel. 6872672  
Email: wamhc@vsnl.net

*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](mailto:wamhc@vsnl.net). Write to us with all your suggestions, criticism and viewpoints on the issues covered.

Another provision of the Mental Health Act makes improper reception of persons with mental illness in a psychiatric hospital or a nursing home punishable. Improper reception means wherein a procedure of admission other than the one provided by the statute is utilised. This offence is punishable with imprisonment up to two years or with fine up to Rs.1,000/- or with both. With such like penalty the above said offence in accordance with the classification provided by the Code of Criminal Procedure is non-cognizable. This classification means that no policing authority will investigate the above said offence without an express order from a magistrate. Once again citizen enforcement will be difficult. Furthermore a question will arise whether private custodial houses like those around Erwadi could be categorised as psychiatric hospitals and nursing homes.

A registration - licensing regime also subsists under the Persons with Disability Act, 1995. This statute requires permission to be obtained from the competent authority before an institution for persons with disability can be established. Disability has been defined to include mental illness. Consequently without obtaining such permission institutions for housing persons with mental illness cannot be established. And licenses of institutions, which breach the statutory regimen, can be revoked. Even as infringement is not criminally punishable an option of reporting to the Chief Commissioner or the State Commissioner of disability exists. These Commissioners have been empowered to take necessary steps for protecting the rights of persons with disability. These necessary steps have not been described in the statute, but should, through a process of interpretation be held to include release, rehabilitation and compensation of persons with mental illness in illegal custody. The Commissioners can themselves take note of the breach of rights of persons with disability or a complaint to this effect can be made before them by any person in the know of such infringement. The Persons with Disabilities Act is a recent statute. In the absence of express remedial procedures the possibilities of the law for persons with mental illness in need of institutional care will primarily depend upon the activism of individual Commissioners.

A process of enforcement alternative to these special legislations exists within the general criminal law. Sections 339 and 340 of the Indian Penal Code define wrongful restraint and wrongful confinement. Where wrongful confinement subsists for ten or more days it is punishable with three years imprisonment and fine. This punishment makes the offence cognizable, which means that policing authorities are under an obligation to initiate investigation upon receiving information of the offence. The treatment

meted out to persons with mental illness at Erwadi and other such places comes within the definition of wrongful confinement. Criminally proceeding against the perpetrators of such like practices is perhaps the most potent of all the options mentioned above. As in contrast to enforcing licensing regulations, upholding the criminal law of the country is a non-negotiable duty of policing authorities.

Other than the above described statutory regimes the Constitution of India guarantees to all persons the right to life and liberty. This right cannot be deprived except by a procedure, which is just, fair, and reasonably contained in a duly enacted legislation. These appellate courts also have the power if they think fit to grant compensation for the inflicted deprivation. This remedy can be activated bonafide by any public-spirited person on behalf of the deprived individuals. A large number of public interest actions have been filed in several High Courts and the Supreme Court of India on the abysmal conditions prevailing in the mental hospitals in the country. Consequent to these petitions the apex court has laid down guidelines for living and treatment conditions in mental hospitals and also ordered the discharge of persons who have recovered from illness. These petitions have provided symptomatic improvement in a specific hospital or provided relief to a particular individual. However no kind of structural reform of the mental health system has happened because of the public interest actions. The one major gain of these petitions is acceptance of the premise that persons with mental illness are bearers of rights. And these rights when infringed should be redressed. Persons confined in the Erwadi custodial houses are being definitely deprived of their life and liberty and there is no legal procedure, which authorises this deprivation. Consequently both the concerned High Court or the Supreme Court can be approached to seek the release of the confined persons. The difficulty here of course is where should the persons with mental illness be housed upon release as so many of them have been abandoned in these places by their kith and kin.

The legal regime mapped out above is aimed to show that there are legal norms for the institutional care of persons with mental illness. For these legal norms to become the ground reality of persons with mental illness it is important that there is a ground swell of self advocacy backing them as it is in advocating their own rights that persons with mental illness have been most handicapped.

*Amita Dhanda, a well known disability advocate,  
can be contacted at [amitadhanda2000@yahoo.com](mailto:amitadhanda2000@yahoo.com)*

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# The Protection Of Human Rights Act, 1999

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The National Human Rights Commission was instituted by the Protection of Human Rights Act, 1999. Nowadays there is a tendency to file cases with the NHRC because of its promise and easy access. However, what is the framework of this Authority, and what are its powers and limitations?

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The NHRC is constituted of senior members of the central and state jurisdiction. It depends on the central government for funds after due allocation made for this by the parliament. Grants from the state government are also given subject to conditions. The annual report of the commission has to be sent to the central government and received by the house of parliament. These reports have also to be made at regular intervals and published.

The commission is mostly an advisory body having powers to intervene in proceedings involving any allegation of violation of Human Rights pending before court. Other work includes human rights literacy, the rights to review, inspect, study, and promote research and NGO activity. It has the powers to summon and enforce attendance of witnesses and examine them. It can also demand any public record or document and demand the services of any officer or investigation agency of the central government and the state government for purposes of completing any inquiry. The commission can recommend various steps to be taken by the government and approach the Supreme and High Court for implementing these proposals. The commission shall be deemed to be a civil court when necessary and every proceeding before the commission shall be deemed to be a judicial proceeding. For speedy trial of offences, the state government may specify for each district a court of session to be a human rights court to try the said offences. For every human rights court, the state government shall specify a public prosecutor or appoint a highly experienced advocate.

The Commission can, among others, review factors that inhibit the enjoyment of human rights, review the safeguards provided under the Constitution or any law for protection of human rights, undertake and promote research in the field of human rights and study the living conditions of the inmates of any institution under the control of the State Government where persons are detained or lodged for the purpose of treatment, reformation or protection and make suitable recommendations for protection and promotion of human rights.

What are the ground realities that delimit these powers? The Commission functions as a searchlight, by conducting valuable investigations. However, it remains more or less an advisory body and it suffers from various limitations such as the lack of the tools required for implementation. For example, the commission cannot inquire into any matter after the expiry of one year from the date on which the act constituting violation of human rights is alleged to have been committed. Lack of enforcement power seems to be another important limitation to the powers of the commission. The fact that they are open-ended and therefore it is easy to “show” compliance with them, although valuable, might undermine recommendations of the committee. The most important limitation is that the commission deals with the cases of violation on an ad hoc basis. It deals with cases, which approach them, but does not have any mechanism to reach the needy. However, persons committed to mental institutions may not always be in a position to seek justice, and therefore may never be able to appeal the commission. The limited provisions must be used effectively while at the same time for greater recognition of the human rights of those with psychiatric disabilities.

*(Source: Protection of Human Rights Act 1999, available from NHRC, New Delhi.)*



# Malatitai Ranade – A Tribute

(August 10<sup>th</sup> 1917 - October 4<sup>th</sup> 2001)

Ujwala Mehendale

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“Malatibai fought with the concerned authorities over many issues. Her deepest concern was with inmates’ proper treatment, right to psychosocial rehabilitation, human dignity and fundamental rights. After retirement, she filed a number of cases against the state government authorities where she felt the inmates’ human rights had been violated.”

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“Malatibai was a hard taskmaster, affectionate and broad-minded. She was my teacher, my elder sister, my family friend and what not...”

“Malatibai was a crusader for justice. Unable to tolerate injustice of any kind, she always stood by the side of the wronged ones ... She instilled in us the spirit to fight against injustice.”

“Only because of her dynamic presence, the team spirit was maintained in the larger interest of rehabilitation, keeping professional ethics intact and built around the core of sincerity and dedication.”

These remarks made by Sudhatai Datar and G.R. Golam, both senior colleagues of Malatitai Ranade spoke volumes about Malatibai as a social worker and as a person. Malatibai Ranade was among our country’s first officially recognized psychiatric social workers who graduated from the Tata Institute of Social Sciences. From the time of joining Yerawada Mental Health Institute in 1949, mental health was her life and mission. Malatibai’s spirited presence at Yerawada spanning 24 long years of service was nothing but distilled and pure Mental Health Advocacy, even that, at a time when these words were totally unheard of.

Malatibai not only had the formidable task of proving the necessity and credentials of her own post in an asylum- that of a psychiatric social worker- but she also had to establish her own role, its scope, functions and daily activities, being faithful to her education and training. The credit for establishing a well defined and documented system of case work, a system of fact finding, home visits, diagnosis, all aimed at rendering better treatment to the inmates at Yerawada goes entirely to Malatibai. In fact home visits, a very necessary activity in rehabilitation, was initiated by her against all odds. It was considered

‘unnecessary’ by the institute authorities. Malatibai paid for every single home visit that she made during her service.



Late Malatitai Ranade

Malatibai was appalled to see the living conditions of the mentally ill at Yerawada. She was openly critical of the Visitors’ Board appointed by statute to look into the Institute’s functioning. Most of the Board members were government officials. Instead of patient welfare, trivial issues were given top priority. Malatibai fought with the concerned authorities over many issues. Her deepest concern was with inmates’ proper treatment, right to psychosocial rehabilitation, human dignity and fundamental rights. After retirement, she filed a number of cases against the state government authorities where she felt the inmates’ human rights had been violated.

During her long career, Malatibai dealt with more than 10,000 patients. Being the only psychiatric social worker at the Institute initially, she was at times looking after over 200 patients single handedly. Malatibai had many ideas and suggestions to improve the quality of treatment and service rendered. This is amply evident in her writings, especially her book, *Manorugna: Katha ani Vyatha* (‘Mental illness- Stories and Miseries’) which won the State Govt. Literature Award in 1982.

Even after retirement Malatibai continued to work with those in need of help. Counseling activities were in full swing, free of cost, of course, till the very end. She was an avid reader, promptly applying newly acquired knowledge in her day-to-day work. She was lively, alert, gracious...her usual self till her last. She lived a full, long life, totally committed to mental health, which ended at the age of 86.

The highest tribute we all can pay Malatibai would be in being committed to strive for greater well-being for those labeled mentally ill in our own capacities and safeguarding their human rights.

*(Special thanks to Sudhatai Datar who generously shared newspaper clippings diary jottings, Malatibai’s book and most precious of all, Malatibai’s memories. She also kindly forwarded Mr. Golam’s letter.)*

*Ujwala Mehendale is a free lance writer in Pune and can be contacted at [ujemi@yahoo.com](mailto:ujemi@yahoo.com)*

## Erwadi: The Chronology

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In a desperate effort at providing 'symptom relief', the Jayalalita Government paid compensations to the families of people labeled with mental illness, who were abandoned in Erwadi shelter and who later perished in the fire. This irrational 'treatment' by the Government, compensating guiltily for its own lapses, only gives out the message that if you abandon a relative to an unscrupulous free market in the name of treatment, and that relative perishes due to cruelty or neglect, then you stand to gain. A chronology of Erwadi events ...

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April 2000- Diarrhea deaths at Erwadi. Recommendations made included provisions for a ward at the district hospitals in Ramanathapuram and Madurai; a training programme for doctors and paramedical staff in treatment of mental patients and for NGO's.

6.8.2001- Death of 25 mentally ill patients at Erwadi who were chained to their beds. After their hutments caught fire, they were burnt alive. 11 women and 14 men died when the fire broke out at 5. 10 a.m. There were 43 persons housed under primitive conditions inside a thatched hut. The police suspected that the fire may have been caused by an oil lamp, which ignited the shed. The alarm raised by some inmates was ignored by the people and asylum owners, who mistook it to be their usual cries. The hostel owners charged that some 'mysterious persons' had set fire to the thatched building. The police took into custody four members of the family, which ran the institution.

Immediately, chief minister Jayalalitha announced a payment of Rs. 50,000/- each for the families of the deceased, Rs. 15,000/- for those who suffered serious burns and Rs. 6000/- for those who had simple burns. The Ramanathapuram DC Vijaykumar announced financial assistance of Rs. 10,000/- to the relatives of the deceased. The district administration and local MLA appealed to the State Government to regulate the private trade.

According to an earlier investigation, the conditions in the majority of the asylums were deplorable. No proper rehabilitation was offered. Mostly untrained attendants were employed to take custody and the "treatment" always included physical torture. The officials claimed that the practice by private asylum owners receives political and upper class patronage. The *TOI* reported on 8<sup>th</sup> August that earlier the DMK government had ordered a thorough probe into the running of the asylum and also arranged a transfer of psychiatric patients to the government hospitals for free treatment.

A five member team comprising of psychiatrists and social workers from the Institute of Mental Health, Chennai, visited 17 institutions for the mentally ill at Erwadi to evaluate the conditions there and an "open" offer was made to shift them to medical facilities. It was suggested to shift them to the Institute of Mental Health in Chennai or Madurai. Immediately after the visit, a psychiatrist was posted at the Erwadi PHC.

The team made a proposal to the center that it start a district mental health program at Ramanathapuram district with an outlay of 1 crore. The program would concentrate on training medical and non-medical officers, mental health care delivery systems (starting *taluka* level satellite clinics) and awareness building measures.

On the 7<sup>th</sup>, the toll of death increased to 27 as two more women succumbed to injuries. 2 information cells at Erwadi and Ramanathapuram were opened for the benefit of relatives and parents of the deceased.

On the 7<sup>th</sup>, the NHRC issued a notice to the T. N. chief secretary and asked for a report on the accident and the steps planned by the government. The commission asked for a reply within one week. The Central Council for Health & Family Welfare, in a meeting, discussed that mental health would be one of the five core areas of investment in the 10<sup>th</sup> five year plan, wherein the MHA would be implemented in the deviant States and hospitals modernised. The budget outlay was reportedly 155 crores (11-8-01, *The Hindu*). On the same day, *the Hindu* also reported that the Center was "toying" with the idea of exempting custom duties for certain psychiatric drugs.

A 5 judge bench of Supreme Court issued notice to the state of Tamil Nadu and other authorities concerned to submit a "factual report" with regard to the incident. This bench included Dr. A. S. Anand, K. T. Thomas, R. C. Lahoti, N. Santosh Hegde and S. N. Variava. They "raised important questions concerning the human rights of a mental asylum".

In a LS meeting, Vaiko (MDMK leader) observed that despite the mental health authority, the state

government had failed to implement guidelines and terrible conditions prevailed. P. C. Thomas (Kerala Congress M) demanded that a central fact finding committee be set up for the state.

District administration drew up a contingency plan to streamline the private asylums at Erwadi. The Government imposed a ban on keeping the inmates of these homes in fetters at Erwadi. The Central Mental Health Authority also cited guidelines against cruelty. Nearly every newspaper report was strewn with mention of the Mental Health Act, the Lunacy Act, news from Mental Health Authorities, Human Rights Commission, SC Judgements and even the UN Principles for the protection of persons with mental illness.

District administration recommended that all private asylums at Erwadi be closed. Patients (about 1000) were ordered to be shifted to special wards in district government hospitals. Orders were issued not to admit people in these asylums and to close them. By the 10<sup>th</sup> of August, patients brought in by relatives were chased away. The dargah management was directed to provide infrastructural facilities to visiting pilgrims under the supervision of revenue officers and police. The management offered co-operation in the matter of streamlining facilities.

Soon after, the Union Health Ministry decided to map out all the 'faith healing' centers frequented by psychiatric patients. Health Minister Dr. C. P. Thakur decided to convene a meeting of state health secretaries and district commissioners to work out the modalities for an effective implementation of guidelines issued recently for the maintenance of minimum standards in mental health set ups.

The moment a family reached Erwadi with a mentally ill patient, a swarm of brokers used to accost them offering the "best" treatment at nominal cost, ranging between Rs. 1000-2000 per month. People having no or



very little idea about mental health were running 16 mental asylums. The brokers were reported to be the "dregs" of society, constituting "hard-core" alcoholics, womanizers and marijuana addicts (8-8-2001, *TOI*). Only 1/3 of the fee recovered from a patient was reportedly spent. They were kept in deep misery with food very often inedible. Sometimes food was adulterated deliberately to get more money from the patient's relatives under 'special treatment'. Women were also sexually molested at these asylums.

Reports of very similar situations where patients are kept chained in centers of faith healing have been reported from Patiala, Bombay, Tamil Nadu and Hyderabad. In an open publicity drive, some state mental hospitals presented glowing pictures of their functioning in the newspapers! One report in Pune Times (8-8-01) read '*No chains in Asia's largest mental hospital*'!!

The SC has since constituted a committee to enquire into the implementation of the MHA and SC orders in all the States.

Will yet another Erwadi happen? A 155 Crore question!!



### From the editorial desk

This issue of 'aaina' would not have been possible without help from Seema Kakade, Lalita Joshi, and Deepra Dandekar of the Center for Advocacy in Mental Health. Marion Jhunja produced the illustrations for *aaina* at short notice. Various papers, reports, correspondence, etc. have been shared by individuals and organisations with the Center and with *aaina*. We thank every contributor for making *aaina* newsy. This issue carries 30% more content than the last 2 issues for that reason.

We had not planned this issue to be on institutions. It just happened that way. However, we do want to bring out these issues on 'Psychiatric Disability' (No, still not enough materials ...!!) and 'Money matters in Mental Health'.

Why the latter topic? We have been wondering about - How much it costs to stay in a hospital for treatment of an acute psychiatric crisis? What is the cost of medication for a month to families and users? Therapy...?? Etc. etc. These are vital questions from a consumer point of view.

So do continue to write in, on these issues, or other ...



# Erwadi Holocaust - An investigation

## People's Watch- Tamil Nadu

Had the National Human Rights Commission completed its hearing on a complaint sent on 13<sup>th</sup> September 2000 by Mr. Henri Tiphagne, Executive Director of People's Watch – Tamilnadu, which has been numbered as case No. 652/22/2000-2001 FC, the inhuman holocaust of 27 most vulnerable and helpless persons would not have happened at Badhusa mental health home run by Mr. Mohaideen Basha at Erwadi. This is the conviction of the fact finding team of People's Watch – Tamilnadu consisting of Ms. Andal, Ms. R. Thilagam, Prof. Xavier Arockiasamy, Mr. Paneer Selvam, Ms. Lalitha, Mr. Pandian, Prof. Rajaram, Mr. M. Feroz Khan -which visited the fire-devastated home and other mental health homes at Erwadi.

The original complaint with the NHRC was related to one Mr. Murugan who was kept in illegal custody as a mentally disordered person in new LIMRAS, a mental asylum. This was done at Erwadi at the instigation of Mr. Kalaivanan, IAS, who was then the Director of Rehabilitation and Physically handicapped in the Government of Tamilnadu, for falling in love with his daughter. Responding to the complaint lodged by PW-TN, Mr. Venugopal, IAS (Retd), the Special Rapporteur of NHRC, did make a field visit in October 2000 and visited the asylum in which Murugan was detained. During his visit, we handed over to Mr. Venugopal a report on the conditions of mental health homes at Erwadi which was prepared by the PW-TN study team immediately after the outbreak of epidemic in which nearly 8 persons died. A video cassette relating the pathetic conditions of the asylums was also presented to him. Around the same time on October 3<sup>rd</sup>, 2000, NHRC served a notice to the Chief Secretary on the Murugan case. Nine months later, the Director of PW-TN addressed a letter to the honorable Commission seeking current position of the same case. If the case had been taken on priority basis and if NHRC had effectively conducted the proper hearing, things could have improved at Erwadi and this poignant tragedy could have been averted.

Mental health homes run by private parties have nothing to do with the Erwadi Dargah. Making use of the throng of people with mental disorders frequenting the traditional pilgrimage cum healing centre, these private parties have been exploiting people for the last ten years. All inmates are lodged in temporary sheds made of coconut fronds. The sheds are so overcrowded that there

is no space to move around. Moreover the inmates are either chained down or chained to a companion. The places look like cattle sheds. Contrary to human rights norms and standards, the mentally disabled people are lodged in such a pathetic condition. Much worse, even some persons thought to be troublesome at home, have been admitted to these homes and chained along with others. Thus, these homes are not only used for housing the mentally sick but also for detaining other persons with the connivance of the proprietor of the homes, as happened in the case of Murugan.

Not only hygienic conditions in these homes are bad, but also there is no proper medical attention. A person attacked by jaundice was just lying along with others in a home called New LIMRAS run by one Mr. Paneer Selvam. In the same home, a youngster allegedly having some sex abnormality is made to stand all the time by chaining his hands to a hanging chain near the lavatory, instead of being taken to a relevant medical personnel. Such is the blatant violations of human rights of these mute victims of mental disorders.

Of late, after the constitution of a Committee to oversee the running of these homes appointed by the district administration, it appears that there had been occasional interactions between the proprietors of the homes and the local government officials. Neither could the team get hold of any written documents in this regard nor could we see any palpable change in the situation of mental patients, since the first field study conducted by the PW-TN team in May 2000.

Some of the inmates have been brought over here after prolonged treatments in government mental hospitals elsewhere. In a few cases, persons getting back to normalcy have been detained in these homes under some pretext or other to carry on odd jobs free of charge in these homes.

The present pathetic incident also clearly indicated the total failure of the District administration in not responding to the systematic exploitation of the mentally challenged patients over a period of ten years by unqualified and avaricious persons.

There is overwhelming reaction both from the public and the trustees and committee members of Dargah that the private so-called mental health homes should be immediately closed down; because of their exploitative



and anti-social character. Strangely, no one was talking about proper, scientific medical treatment of the innumerable patients. The Dargah people, however, have expressed the willingness that if the Government were to establish a mental health facility in this area, they would extend support and help.

In the light of these findings by the team, the following recommendations were made to the appropriate authorities by PW-TN.

1. There should not be any second thought about closing down the private mental asylums but then before the phasing out procedure is launched, a team of mental health professionals should be requisitioned to assess the health status of each and every individual lodged in these homes and then only they should either be handed over to their kith and kin or to any other legally sanctioned mental health centers run by government or non governmental agency for proper rehabilitation.

2. (a) In view of the traditional belief that mental disorders get cured in Erwadi Dargah, the establishment of a government mental health centre is recommended, with a task of not only treatment but also to carry on mental health education in this place.

(b) On this occasion, it would be more appropriate to initiate the above mentioned pro-active measure in other traditional religious healing centers as well.

3. Wherever such mental health centers are established, monitoring committees consisting of members of the respective religious organizations, reputed NGOs and Government officials should be appointed and given free hand to implement the various norms and standards recommended by the appropriate legal authorities.

*Source: Press release and Study by People's Watch, Tamil Nadu.*

*Mr. Henri Tiphagne, Director, PW-TN and the other activists may be contacted at [henri@pronet.net.in](mailto:henri@pronet.net.in)*



## Pax-Beware

*“...jolting electric ‘zaps’ that coursed through our bodies, dizziness, lightheadedness, vertigo, in-coordination, gait disturbance, sweating, extreme nausea, vomiting, high fever, excruciating abdominal pains, anorexia, diarrhea, agitation, tremulousness, irritability, aggression bordering on violence, sleep disturbances and nightmares, loss of memory and confusion, difficulties in concentrating, lethargy, fatigue and many other problems ...”*

In December 1992, an anti-depressant in the same class as Zoloft and Prozac (Serotonin Selection Reuptake Inhibitors) was approved for marketing in the United States for conditions of depression, obsessive-compulsive disorder, panic disorder and ‘social anxiety disorder’. It caused some users to experience serious and unexpected withdrawal reactions about which the manufacturer Glaxo Smithkline Corporation (formerly known as Glaxo Smithkline Beecham) failed to warn due to the fear of loosing its market among other anti-depressants. GSK has known for years about the distinct characteristics of Paxil, which make it prone to cause withdrawal reactions when discontinued and in fact causes severe physical and psychological dependence. However this information was not shared with the doctors or the users, making this case comparable to the Tobacco scam.

On August 24 2001, 35 people who suffered from severe withdrawal filed the first class action complaint of its kind in California Superior Court, LA County, against GSK. The complaint charges include fraud and deceit, negligence, strict liability, breach of warranty and implied warranty. The lawsuit was filed by Karen Barth with Mary Schiavo of Baum, Hedlund, Aristei, Guilford & Schiavo in LA and Donald Farber in California: “The scariest part is that there are people who are trying to get off this drug who are experiencing these horrible withdrawal reactions. They think it’s because of something wrong with them, when it’s really the Paxil...and then they take even more and exacerbate the problem!”

We look forward to the outcome of this case. Users forced into addictions to prescription drugs can see litigation as an important way of seeking redress and controlling bad trade practices.

*Source: [www.baumhedlundlaw.com](http://www.baumhedlundlaw.com)*

## “Be a good patient, now ...”

### Excerpts of an interview with Malati Ranade (1980)

“A well-behaved patient is one who sits quietly in one place for hours together, one who accepts cold tasteless food without any complaint or a meagre cup of cold tea without a murmur of protest, one who is completely docile and dumb, a person who accepts being herded like cattle into halls and from halls to wards, a person who accepts dirty soiled mattresses and stinking sheets and does not complain about disturbed sleep. Such patients are considered good patients by the staff, people without a spark of life, who it is very easy to keep in ‘safe custody!’”

Malati Ranade, in one of her interviews to *Sree Weekly* (September, 27, 1980) said that a majority of patients who are on the path of improving never recover fully because of lack of affectionate human contact and inhuman living conditions.

- There was only one tap for the purpose of taking baths as well as drinking water
- Walls were red with dead bedbugs and most patients couldn't get any sleep at night
- Every resident was given a bath twice a week. 10-12 patients were shoved into one bathroom, in the nude. The attendant first poured soap water and then threw a few mugs of water to wash off the soap. Towels were not adequate, and seldom the patient got clean clothes to wear.
- No wonder, the patients were found to be suffering from white lice on their bodies.
- The patients never got food on time, because sufficient numbers of plates were never served
- Preparing tea: when 40 kgs. of Sugar was required only 9 kgs. would be used, and instead of 80 litres, only 40 litres milk would be used.
- The ‘Ayahs’ were called ‘Rakshashinis’ (*she-demons*) by the residents, and the psychiatrists as ‘shock-doctors’, as they did not provide any treatment other than electric shock (E.C.T.)
- Once, a 25-year old lad died within 9 months of admission. During this period he did not get any treatment other than 17 electric shocks. Records did not mention any severe disease as a cause for his death. Five months after his admission, he was transferred to

the ward for ‘weak patients’. Later one day, he was recorded as ‘serious’, and the next day the register recorded his expiry. There was no discussion about this death. (In a recent talk with Malati Ranade, she mentioned that authorities held what was notoriously called ‘Mortality Meetings’ to discuss these deaths.)

- Medical staff was under employed, as very few patients required ‘medical treatment.’ These doctors had to spend most of their time in playing chess! (Nowadays they have thriving private practice).
- In 1980, there were 1100 employees at the hospital to look after 2700 patients in Yerawada. Still no one arranged recreational activities or rehabilitation.
- Crores of rupees were spent on the hospital, however only one third of the amount was spent directly on the residents. Even in the monies spent, quality of food, clothing, etc. was questionable.
- None of the state authorities bothered to follow the provisions under Indian Lunacy Act. The Visitors’ Committee was supposed to visit the hospital and monitor conditions. However, during her long tenure, neither did this committee ever take a single round in the whole hospital, nor did it find a single objectionable instance, although misappropriation, apathy and cruelty towards the residents were an everyday practice.

*Source: Malati Ranade Papers, Bapu Archives, Pune. We are very grateful to Late Malatitai Ranade for donating several of her papers and documents to our Archives. Sourced by Seema Kakade.*



## For your information ...

For the wandering mentally ill who are treated cruelly, who languish in lock-ups and jails like criminals, for the many workmen who get mercilessly thrown out of their jobs on grounds of mental illness, for the women who are deserted or divorced on grounds of 'insanity', for those illegally confined within various types of institutions and those who cannot afford legal services because of their confinement within institutions, this appears to be a useful Service Authority.

The National Legal Services Authority, on the occasion of "Legal Services Day" (9<sup>th</sup> November, 2001) reiterated its resolve to ensure "Equal Justice to All". According to the Preamble of the Legal Services Authorities Act, 1987, the Act is to constitute Legal Services Authorities to provide free and competent legal services to the Weaker Sections of the Society to ensure that opportunities for securing justice are not denied to any citizen by reason of economic or other disabilities and to organize Lok Adalats to secure that the operation of the legal system promotes justice on a basis of equal opportunity.

Who is eligible to get free legal aid under the Authority:

Any person who is either a member of a SC / ST; or a victim of trafficking in human beings or 'begar' as referred to in Article 23 of the Constitution of India; or a woman or a child; or a person with disability as defined in clause (i) of Section 2 of the Persons with Disabilities Act 1995; or a victim of mass disaster, ethnic violence, caste atrocity, flood, drought, earthquake, or industrial disaster; or an industrial workman; or in custody, including that of a protective home, juvenile home, psychiatric hospital, psychiatric nursing home; or having annual income less than Rs 9000/- or such other higher amount, as prescribed by the State Government if the case is before a court other than the supreme court, and less than Rs 18000/- or such other higher amount, as prescribed by the Central Government if the case is before the supreme court.

Eligible persons may contact the following for obtaining free legal services:

- ♦ Secretary, SC Legal Services Committee

- ♦ Secretary, High Court Legal Services Committee
- ♦ Member-Secretary of the State Legal Services
- ♦ Secretary of the District Legal Services
- ♦ Taluka Legal Services Committee

Legal Aid means and includes advocates to eligible persons; court fee on behalf of the eligible persons; expenses regarding typing and preparation of petitions and documents; expenses for summoning of the witnesses on behalf of the eligible persons; and other expenses incidental to litigation. All the expenses for litigation are borne by the Legal Services Authorities. The aided person is not called upon to bear any expenditure whatsoever.

For more information log on to <http://supremecourtindia.nic.in>

(Resources: *The Legal Services Authorities Act, 1987*)

Contact: S.M. Chopra, Member-Secretary, National Legal Services Authority, 12/11 Jam Nagar House, New Delhi- 110 001 (T)- 011-3382121, 3385321 Email: [nalsa@bol.net.in](mailto:nalsa@bol.net.in)



**dear aaina**

Thank you very much for sending us the second issue of 'aaina'. It is very evident, a great amount of quality team work has gone into the making of the newsletter. It is very impressive and informative with a wide range of topics. "Aaina" is a shot in the arm of mental health advocacy in India. I hope this will become a permanent publication after the first three trial issues. Please accept and convey to other members of your team, our hearty congratulations and best wishes.

Mr. B. Raju ([scarf@vsnl.com](mailto:scarf@vsnl.com))  
Chief Administrative Officer  
Schizophrenia Research Foundation (India)  
Plot R/7A, North Main Road,  
Anna Nagar (West Extn)  
Chennai 600 101

Your letters and responses will find a place for our readers in this column. We may not be able to publish all letters nor letters in their entirety.

## On Non-Compliance

*What is the letter of the law with respect to treatment rights in residential facilities? Justice S Mohan on 17<sup>th</sup> August 1993 disposed off Writ Petition (Cri) No. 237 of 1989 (Sheela Barse Vs Union of India & Anr) in the Supreme Court of India, by directing the Chief Secretary of every State to ensure that its order for West Bengal is properly implemented in every other state as well. The MHA 1987 was notified on 22.5.1987. The Central and State Mental Health Authority Rules 1990 were notified on 29.12.1990. Vide letter of 10.11.1981, the Central Government also requested all State Governments and Union Territories to establish the State Mental Health Authority in compliance with the MHA. Yet, till today, many states openly ignore the statutes, the administrative orders as well as the SC orders. If the situation of non-compliance to statutory regulation prevails, Erwadis will continue to happen. Relevant excerpts from the SC Judgement...*

“The improvement schemes for mental hospitals are outlined as follows:

“It is suggested that managing bodies should be set up for all hospitals ... Senior officers from the department of health, welfare, prisons, police along with a professor of psychiatry from a teaching hospital could be members. The medical superintendent of each hospital could function as member secretary of the committee.

“These committees will be under a duty to formulate schemes for improving both the living and therapeutic conditions in mental hospitals. The aim of improvement schemes however should not just be to remove the deficiencies of the old hospitals but to create and to transform these old custodial institutions into active treatment centers supportive of care in the community.

“Legal Aid: A mentally ill person shall have the right to legal representation and legal aid in involuntary commitment proceedings before a magistrate.

“Admission to mental hospitals: A person who believes he needs in-patient treatment in a mental hospital for his mental illness makes request for voluntary admission to the medical superintendent of a mental hospital. ...The medical superintendent subsequent to necessary inquiries may grant admission. A voluntarily admitted patient shall be discharged within 24 hours of his or her making request for discharge.

“Living and therapeutic environment of mental hospitals: The state shall ensure that all the mental hospitals in the state should provide a clean and healthy environment, effective care and treatment to mentally ill persons. In order to enable performance of this function all mental hospitals shall be allocated commensurate resources.

“Emergency medical aid and death in jail or mental hospital: The medical superintendent or the jail superintendent (till the mentally ill are in jails) shall be responsible for the medical needs of the inmates of the medical hospital and jail respectively. The above stated officers shall ensure that their institutions are equipped with life saving medicines and immediate medical attention is given to any inmate who needs it. The state government shall respond at once to medical superintendent’s request for life saving drugs or any other emergency medical help. If a mentally ill person in jail or mental hospital dies in unusual circumstances a post mortem shall be carried out.”

The judgement exhaustively covers restoring the liberty and rights of persons with psychiatric disability illegally confined in jails and the wandering ill. It acknowledges the treatment deprivatory consequences of being committed to jails, the delay in receiving specialist help, the lack of specialized human resources and supervised care. The judgement also notes the lack of variety of treatment facilities and excessive deprivation of liberty in the jails.

*The full text of the judgement and various other related papers and documents were shared with us by Ms Sheela Barse.*

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## **Protest against violation of human dignity at Ervadi Mental Home, Tamil Nadu, held at Apte Prashala on 18<sup>th</sup> August, Saturday, 2001, at 4.30 p.m.**

Around 50 activists and concerned people and organizations attended the meeting. Sadhana Natu gave the context for the meeting. Speakers were Manisha Gupte (MASUM), Dr PT Lavatre (Yerawada Mental Health Institute, Pune) and Bhargavi Davar (Bapu Trust). Anil Vartak (Ekalavya) and Mrs Bapat (Schizophrenia Awareness Association) spoke about the stigmatizing nature of our society towards those labeled mentally ill. The role of closed-door hospitals in treatment or maintaining dignity of patients was questioned. A signature campaign was taken out demanding the following.

1. States should implement the MHA and enforce SC and HC rulings
2. Persons labeled with psychiatric disabilities must be included in all welfare schemes and benefits given through the Persons With Disabilities Act, 1995
3. Law should cover care and treatment rights
4. Justice should be served to victims of ERVADI holocaust

Letters were sent to Maneka Gandhi, Hon CJI, Mr Anand, NHRC Chief and the Chief Commissioner of Disabilities. Mr Acharya ended the event by showing appreciation of the solidarity of feelings, which brought everyone here.

## **National Federation for Mental Illness [NFMI], New Delhi**

Recently, a national coalition of Carers' groups and organizations has been formed, called the National Federation for Mental Illness [NFMI] in New Delhi. The Society has broad objectives, including: Stimulating the growth and access of mental health services and rehabilitation programs; improving the quality of life of persons with mental illness; assist persons with mental disability towards self support; influence the media; eradication of stigma; encourage self help groups; promote and advocate for full realization of the rights of persons with mental illness; express opinion on proposed legislation; Encourage and support research; encourage best treatment practices and ethical conduct.

For more information, contact:

Sh. S.D. Raheja, President, NFMI,  
8/276, Sunder Vihar,  
New Delhi-110 087.

## **Karnataka Association for Psychiatric Disability (KAPD)**

In a significant development, Karnataka Association for Psychiatric Disability (KAPD) along with other carers' groups in Bangalore sent out appeals to the Ministry for Social Justice and Empowerment seeking inclusion of Persons with Psychiatric Disability in the National Trust Act, 1999. This is a move to further push for the implementation of PWDA, 1995 in the area of psychiatric disability. The PWDA promises equal opportunities, non-discrimination, full participation and protection of fundamental rights for persons with all types of disability, including psychiatric disability. However, the National Trust Act covers only autism, cerebral palsy, mental retardation and multiple disabilities.

More information on this advocacy initiative can be obtained from KAPD, C/O The Richmond Fellowship Society, 'Asha', 501, 47<sup>th</sup> Cross, 9<sup>th</sup> Main, V Block, Jayanagar, Bangalore 560 041.



## Facilitating Legal Activism in Mental Health - Workshop 2

Report by Lalita Joshi

Bapu Trust and India Centre for Human Rights and Law (ICHRL), Mumbai, organised a one-day workshop on the “Mahajan Committee Report” on October 20, 2001 at YMCA, Pune. This workshop was a follow-up of the “Law and Mental Health: Facilitating Legal Activism in Mental Health Care” Workshop held in February 2001 by Bapu.

The objectives of the workshop were –

- ♦ Dissemination of information about the Mahajan Committee Report (MCR);
- ♦ Dialogue with Maharashtra State Mental Health officials about MCR, the status of mental hospitals in Maharashtra and the role of the SMHA in regulation of services;
- ♦ Building a framework for psycho-social rehabilitation of mental hospital patients and the roles and responsibilities of various stake holders, including NGOs;
- ♦ Future of mental health activism in Maharashtra in Mental Health.

The workshop began by paying tribute to Late Malatitai Ranade, a crusader for patients’ rights at the Yerawada Mental Hospital and an erstwhile member of Mahajan Committee. Seema Kakade presented the background to the MCR Report and a gist of the Mahajan recommendations. She also detailed Malatibai’s lasting reservations about the implementation. Some of these materials were also circulated in the form of resource materials.

Dr. Lavatre (Superintendent, Yerawada Mental Hospital) talked about the implementation of the Mahajan Committee’s recommendations in Yerwada Mental Hospital, focussing mainly on physical environment and logistics, such as painting works, construction of new wards, kitchen, toilets, etc. Dr. Doke (Additional Director, Department of Health and Member, State Mental Health Authority [SMHA]) presented the overall status of Mental Hospitals in Maharashtra. Although both the authorities mentioned some improvements in treatments and action areas, the human, psychological elements of patient rehabilitation were left un-addressed.

This session elicited valuable suggestions regarding policy advocacy and advocacy for ethical and professional practices within residential facilities. Ms. Sheila Barse was instrumental in giving inputs regarding the Judgements by SC and HC, and the need for legal and other activism to see that the State has properly implemented them.

For the afternoon session on “Rehabilitation within residential facilities”, a panel comprising of Dr. Katy Gandevia, Dr. Anuradha Patil, Anagha Khot, Dr. Heenal Shah and Dr. Matcheswalla came up with significant suggestions for incorporating patient rehabilitation within mental hospitals. These were: Hospital staff training and awareness on legal issues and SC judgements; Literacy & Awareness, interacting with and organising families within hospitals, Home visits; Expanding the scope of Visitor Board to include patients’ councils or advocates; Volunteer system; Meaningful, structured & individualised rehabilitation programmes; Occupational therapy; Sheltered workshops, Supervised employment, Job placements through the Persons with Disabilities Act; Using external resources and expertise; Involving NGO’s and community in meaningful ways.

Advocacy areas stressed with urgency were: an NGO level consultation on the limitations of the National Draft Policy on Health; addressing mental health reform through the PHA network; pressing for state level interventions to include rehabilitation within hospitals; auditing of general and municipal hospital psychiatric services; and advocacy through the PWDA, 1995.



## The “mandate”

media desk

Post-Erwadi, in an outrageously insensitive and irresponsible interview given to the *Indian Express* (13<sup>th</sup> August, 2001), Maneka Gandhi, (erstwhile) Minister for Social Justice and Empowerment, says she would love to do a lot, provided the “lunatic asylums” are handed over to her ministry. Sreelatha Menon of *IE* wanted to know why, even though mental illness is the seventh and last in the disabilities listed by the People with Disabilities Act, 1995, her ministry has so far not dealt with it. Evading this question, Ms Gandhi responded that she couldn't do anything unless “lunatic asylums are with the ministry”. It is shocking that the highest Minister handling Dept of SJ&E should make these enormously degrading references to persons with mental illness- and even more shocking that she should consider the scope of her ministry's contribution in the area of psychiatric disability to be about “lunatic asylums”!! In response to a pertinent question that Dept of SJ&E could do a lot as it did have powers for supervision, co-ordination, training and rehabilitation, she said that anything she did would be useless as the ministry had no money, and without money, no one would listen!! She warded off several, several questions relating to the central disability committee, their responsibilities, and the many things that Dept of SJ&E can do, other than “regulating lunatic asylums”. Her only refrain was unless her ministry is given “the mandate”, she can do nothing. She didn't want to be “pushed” and wanted to be “left alone”!! Well, mental health consumers will be happy that she has been relieved of her portfolio with the ministry. We'll only be too happy to leave her alone and not have her meddling in mental health.

For the full text of the stunning interview, brought to our attention by Dr Soumitra Pathare, source: [www.Indian-express.com/ie20010813/op1.html](http://www.Indian-express.com/ie20010813/op1.html)

### **“Madness is like evil...” Kamal Haasan on ‘Abhay’**

Roshmila Bhattacharya interviews Kamal Haasan for *Screen* on his new film ‘Abhay’. K Haasan informs us that it is a revival of his once popular Tamil novel called ‘Dayam’ (meaning ‘dice’). The story is about twins, one of them cast as a “psychopath”.

For those of us who are not enlightened, a *psychopath* is a completely media made psycho-diagnostic category, describing a person who stalks friendly and unsuspecting neighbourhoods, usually in the dark, with menacing metallic instruments dipped in tomato ketchup. This character has very little to do with psychiatric disability.

The motivation for the story, according to Haasan, was his own memories of an intimate school friend “turning insane”: *“The memories came crowding in... He'd had such a great sense of humour and an innate knowledge about fashion. He' been so intelligent and such a leader! Reflecting on his admirable traits I realised that they were the qualities of a psychopath too. However, it was still unthinkable that this guy who'd been one of us, had gone over the edge. Did that mean that I was also mad?”*

Is “turning insane” like turning a corner or is it more like turning a new leaf? Are there natural items in the world called “psychopaths”? Do these items have inherent “qualities”? Questions, questions...

Replying to Roshmila's bare and mindless question as to *“Why did the loony guy have to be bald?”* Haasan patiently educates us that in a mental asylum, “inmates” (another peculiar item of our mental health vocabulary) often pull each other's hair. Apparently, to stop them from injuring others and getting injured, their hair is trimmed very short!!

Well, this is a bit like the story of the person who told us that mental asylums don't stock water or mugs in the toilets because the patients may drown themselves in the mugs!! They also keep “inmates” naked and remove fans for similar reasons, to save themselves and others from harm. It is a different matter that “inmates” are living in unsafe, undignified environments and may die of bug bites or malaria.

Aside from the rather evident ‘mentally ill are violent’ theme, Haasan remarks that *“mental illness is like evil...”* and that *“the bad men in this world are usually bald”*. Apparently, the famous commando dagger with which Abhay kills was introduced because of it's metaphorical links with *“the human mind that tapers off in different directions. It even has a hooked beak making it as crooked as Abhay's mind”*.

How many times, Mr Haasan, *but how many times* do we have to say that psychiatric disability is not about being bad or evil?

... the nazis who killed the jews were *not* psychiatrically disabled- neither are the men who beat their wives, nor the men who go to war, nor the men who send other men to war, nor those who poach the elephants, nor those who steal the sandalwood, nor those who pull down the mosque, nor those who fight over borders ...

For a full text of the interview, see [www.screenindia.com/20011109/fcover.html](http://www.screenindia.com/20011109/fcover.html)

## Chandani Bar: A Social *Cul-de-sac*

The movie as many of us know, portrays the tragic lives of bargirls. It has been admired by critics for achieving a good harmony between the commercial approach and the art film approach. The movie begins with the flashback narrative of an old woman Mumtaj. As an adolescent girl, Mumtaj becomes an orphan during the communal riots and comes to Bombay with her uncle, where she is inevitably forced to be a bargirl and remains a bargirl for her whole life. She falls in love and marries, where she is fleetingly happy, until her husband is violently killed in an encounter. In spite of a strong determination and heartrending efforts, she fails miserably to provide her two children a 'white-collar' life. Her daughter ends up becoming a bar girl, and the son, sexually abused by older boys in the remand home where he is sent, turns to violence and the low life. Thus the movie begins with trauma, continues with tragic episodes and ends with trauma. The feelings brought out by the movie were very negative. It was emotionally exhausting to see the helplessness, hopelessness, vulnerability and the vicious cycle portrayed in the whole movie. We want to say, 'life is not always like that' - There is the possibility of healing and overcoming!!

What purpose does such a movie serve? It does not raise any exploratory questions in the minds of the audience about gender, trauma or overcoming. In fact it leaves us with feelings of apathy, diffidence and fatalism – A 'What can we do? Aisahi hota hai!' type of attitude. This only evokes the *cul-de-sac* that trauma is and reinforces a mentality of mute acceptance of the situation and vulnerable endurance. The movie not only evokes

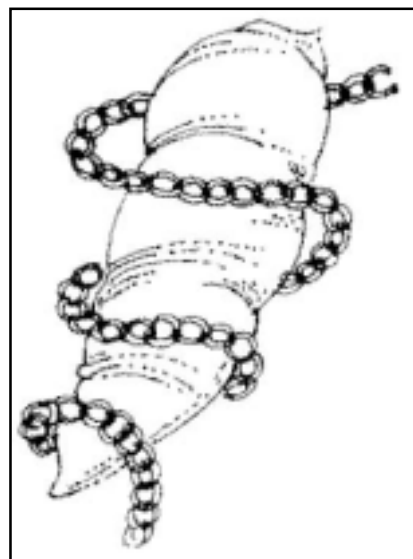
but also perpetuates the same mentality, when it portrays Mumtaj and the rest of the bargirls as helpless, hopeless victims through and through. Portraying the women as 'victims' with little agency or options seems to be a very typical stereotype. Infact, Mumtaj's persistent attempts at making strong choices always seem to end in failures.

The movie perpetuates other stereotypes, which need to be equally challenged. These are:

- ♦ Family and marriage are happy and safe options for women
- ♦ Violence prevails only among people from the lower strata
- ♦ Inevitability of 'destiny'
- ♦ A woman needs a man to lead a decent life
- ♦ It is always a male figure who saves a woman, though he may be exploitative at times

Our experience tells us that families nourish a substantial potential for abuse and that violence is not the symptom of a particular class. Women do live their lives with dignity and without any so-called support. Women do make choices even in the profoundest depth of their miseries. Considering the impact of media on the masses, we feel, it is fundamental for a movie to raise questions and build feelings of hope and healing. Sensitivity and objectivity and doing away with gender and other stereotypes, seems to be an indispensable precondition for that.

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## ‘Save me from my therapist ...’

speaking our minds

Shalini Singh Deo

Our organisation TARSHI (Talking about The Reproductive and Sexual Health Issues) is based in New Delhi. We run a telephone help line that requires a referral panel consisting of health professionals including mental health professionals. It is a constant challenge for us to identify and select gender sensitive, lesbian / gay sensitive, competent professionals. Many of our callers relay their experiences of their interactions with mental health professionals practicing in the city. Some of the narratives are shocking.

When a caller calls to express that she is feeling suicidal *after* meeting her therapist we are reminded again of the callous, insensitive attitude of mental health professionals. Over the years we have received feedback from many callers about a reputed and prominent therapist practicing in Delhi. The therapist in a couple’s therapy situation ‘advised’ the husband to forcefully penetrate in order to alleviate the fear his wife felt towards sex. The husband now continues to have violent sex with his wife and the therapist ‘sympathises’ with him for having a wife who lies passively while he forces himself on her. Another caller faced the same traumatic situation when the same remedy was suggested to her husband. The therapist also advised the client to get a “frigidity report” from a gynaecologist, “frigidity” being an obsolete term removed from diagnostic manuals several years ago! The same therapist also blames her client for being a difficult and obstinate wife and daughter-in-law, because she has chosen not to have a child. She repeatedly admonishes her for not being ‘normal’.

In another situation, a therapist tells the parents of her client that their daughter is 80% lesbian! Though this ‘diagnosis’ made life easier for the daughter, who in fact was attracted to women, it is frightening to know that mental health professionals measure sexual preference! Firstly sexual preference cannot be measured. Secondly, if a person’s sexual preference is put in a percentile form, it can be misused to change a person’s orientation by applying a treatment in relation to the severity of the preference. Another danger is that of the person being labeled and then not having the freedom to change and explore one’s preferences.

The list can go on and on, but I have to mention that a distinguished sexologist in the city offered to find the G-spot of his client who did not experience any sensation during sex. The condition was that he would do it in the absence of her husband and then later show it to the husband. The client was petrified and furious, and did not go back to him.

It is frustrating to know that these unethical, insensitive and incompetent professionals continue damaging people and are not held accountable. They need to be exposed and tried by a peer committee of credible mental health professionals.

*Shalini Singh Deo, working at TARSHI, New Delhi, can be contacted at [tarshi@vsnl.com](mailto:tarshi@vsnl.com). TARSHI runs a helpline for sexual and reproductive health: 011-4622221,4624441. Their website is [www.tarshi.org](http://www.tarshi.org).*

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### Useful Resources

- ◆ “Quality Assurance in Mental Health”, 2000, National Human Rights Commission, Sardar Patel Bhawan, Sansad Marg, New Delhi- 110 001
- ◆ Amita Dhanda, “Legal Order / Mental Disorder”, 2000, Sage Publications, New Delhi
- ◆ The Mental Health Act, 1987
- ◆ The Protection of Human Rights Act, 1999 (NHRC)
- ◆ The Persons With Disabilities Act, 1995
- ◆ United Nations “Principles for the Protection of Persons with Mental Illness”, adopted by the United

Nations General Assembly Resolution 46/119 of 17 December 1991

- ◆ WHO’s “Mental health care law: Ten basic principles”, with annotations suggesting selected actions to promote their implementation. WHO/MNH/MND/96.9
- ◆ National Mental Health Programme, 1982, Government of India, New Delhi
- ◆ “Human Rights and Mental Health: Mexico” Mental Disability Rights International, 1156, 15<sup>th</sup> Street, NW Ste 1001, Washington DC 20005. ([www.mdri.org](http://www.mdri.org))

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## 'Anand Diwas'

Mr Sanjay Chitale from the Yerawada mental hospital, Pune, writes:

*The birds make nests in the Tamarind  
Its leaves and branches slowly breeze in the wind  
The Supari sheds its branches with a bang  
Sometime before night fall the birds on it also sang.  
While everyone awaits the ripe tamarind and mangoes  
Mr John Benjamin dutifully waters  
The tiny papayas for his own reasons  
And the sight of coconuts  
Drives me nuts.*



Picture by- Sushma Bhalgat

(Excerpts from his poem, 'Nature from Anand ward')

In order to create a space for sharing for the Yerawada patients, where no one will say 'don't do this or don't do that', Sadhavi Salunke (II Year MSW student, Karve Institute, Pune) has started a Journal called *Manogat*. There was no money to bring out prints, and so they decided that the first issue would be hand written. In each and every poem, you see the desire to go home. Some patients who were not able to read or write were upset that they didn't have the opportunity to express themselves. So the idea of celebrating 'Anand Diwas' came about. Bhagyashri Pharande, a social worker at the hospital, Sadhavi and the patients together organized a cultural program where folk songs were sung and speeches were made. The women patients were very happy to be wearing sarees with colour. The day really gave positive energies to the patients and also to all the people who are working there.

*Aaina thanks Mr Chitale for his contribution. Sadhavi Salunke can be contacted at [sadhavi2000@yahoo.co.in](mailto:sadhavi2000@yahoo.co.in)*



## The Draft National Health Policy 2001 and Mental Health

Sections 2.10 and 4.10 of the NHP draft deal with Mental Health. The sections note "Mental disorder is more prevalent than visible on the surface. While they may not contribute to mortality, they have a serious bearing on the quality of life of affected persons. Serious cases of mental disorder require hospitalization and treatment under trained supervision. Mental health institutions are perceived to be woefully deficient in physical infrastructure and trained manpower. NHP 2001 will address itself to these deficiencies in the public health sector". Further, "NHP 2001 envisages a network of decentralized mental health services for ameliorating the more common categories of disorders. The programme outline for such a disease would envisage diagnosis of common disorders by general duty medical staff and prescription of common therapeutic drugs. In regard to mental health institutions for in-door treatment of patients, the policy envisages the upgrading of the physical infrastructure of such institutions at Central Government expense so as to secure the human rights of this vulnerable segment of society".

The NHP draft gives data on incidence on kala azar, malaria, small pox, IMR, MMR... It has things to say on epidemiological shifts, status of hospitals, health spending, health infrastructure, number of PHCs, utilization of services. It predicts decrease in various diseases of epidemiological significance like polio and yaws and increase in health indicators. But nowhere in this data, mental health is reflected. *Whatever* happened to the National Mental Health Programme, 1982? Are we scrapping something, which was hailed as a landmark in mental health work during the 1980s? Outside of institutions, if any public sector activity has happened in mental health, it has been through the NMHP, whatever its problems. What is the status of NMHP today?

*Aaina is very interested in polling opinions and covering critical issues relating to the mental health dimensions of the draft health policy 2001. Do write in ASAP to [wamhc@vsnl.net](mailto:wamhc@vsnl.net)*

# Psychosocial Rehabilitation – Experience at a Day Care Center

spotlight

Dr.S.Kalyanasundaram, Dr.Dharitri Ramprasad and Mrs.Suman K.Murthy

Psychosocial rehabilitation is a process by which persons suffering from mental illnesses are rehabilitated using psychological, behavioural, social, medical and vocational methods so that they achieve the maximum possible level of functioning. The aim of rehabilitation is to restore the individual to his/her maximum level of independence, psychologically, socially, physically and economically.

Here we write about “*Chetana*”, a Day Care Center and Vocational training unit run by the Richmond Fellowship Society (India) in Bangalore. *Chetana* was established in 1997. This center functions between 9.30 am to 4 pm during which time the clients are engaged in various activities to enhance their personal, social and vocational skills and autonomy. These include personal hygiene, interpersonal interaction skills with families and others, dealing with day-to-day stresses, problem solving and medication compliance. Relapse identification and management, work habits, improving communication and social skills, time management, eating, table manners, social etiquettes under the guidance of therapists, also form a part of the therapeutic programme. The support staff as well as vocational instructors undergo an orientation programme to develop basic and necessary skills in dealing with psychiatric disability.

*Chetana* is run on the ‘Therapeutic Community’ approach. All the activities are planned to facilitate reintegration into the community. The programmes are conducted in a group setting, which enhances social skills required for day-to-day interaction. The daily programs in the Day center start with morning meeting where the person discusses with the group, the work done by him/her since the previous evening till the next morning. The clients also share two news items from the day’s newspaper, which helps them to keep abreast of current affairs.

The morning session comprises predominantly of vocational training, namely: Typing and Computers, Printing, Plastic Moulding, Tailoring and Embroidery. Other vocational training facilities include operating the telephone, data entry for the Library and horticulture. In the vocational units, the initial focus is on developing attention and concentration, ability to focus on a particular task and comprehending simple instructions. The clients

then learn the skills of the vocation at their own pace which helps to reduce performance related anxiety. Once the client develops sufficient attention and concentration, the skills required for particular vocation is taught to the client according to his/her capacity. The afternoon sessions are meant for therapeutic programs such as group therapy, art therapy, recreation, games, community meeting and vocational training. Once a month the clients are taken for an outing, which might include a movie of their choice.

Close monitoring and immediate referral ensures control of symptoms, better understanding of the illness by the client and the family and prevents relapse. This improves their confidence to handle his/her illness better. Regular feed back is sent to the psychiatrists for follow up keeping them abreast of the progress made by clients. The center provides individual counselling and also family therapy. Meeting and counselling a group of families once a week ensures better understanding and acceptance by the family members regarding their wards’ illness and behaviour.

*Chetana* caters to two main streams of clients: those who need and are interested in some specific vocational training and also to those who would benefit with productive and planned activities. As per the needs of the client and the recommendation of the mental health professionals, psychosocial intervention is planned to facilitate a client to function at their optimum level of functioning. A monthly evaluation is done for all the clients by using an Incentive Assessment Proforma named Assessment Schedule for Incentives (ASI). We are in the process of planning a systematic follow-up of our clients. The center gives special attention to disseminating information on mental health. Job placement services are also offered at the center.

*The authors can be contacted at [rfsindia@vsnl.com](mailto:rfsindia@vsnl.com). RFI offers a 2 year M.Sc. degree course in Psychosocial Rehabilitation affiliated to the Rajiv Gandhi University of Health Sciences. Information about this course can be obtained from Dr Kalyanasundaram’s office at RFI.*

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## This winter I thought of death

Excerpts of a Poem by 'Noah'

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This winter I thought of death.  
As I thought and thought of death  
Death itself fell in step with me  
On my road to death.  
Overjoyed, I whispered: "Be my beloved!"  
And Death replied:  
"My seduction will send you to the grave of  
anonymity.  
No flowers will be laid in tribute to your sacrifice.  
Your protest will go unnoticed.  
Your mother will say: "Yes, he was a  
schizophrenic."  
The police will say: "It was an act of a lunatic."  
The "kind" psychiatrist in the hospital  
will carry on with drugs and ECT as before  
unmindful of your existential suicide."  
I listened and understood her advice.

This winter I thought of death  
And Death finally became my beloved.  
I seduced & made love to her at night.  
It was a one-night stand.  
Death, my lover gave birth to a child.  
She called it "Protest".  
I took my child in my arms, hugged her  
and went out on the street(s)!

...

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