aaina

a mental health advocacy newsletter

Vol. 2 No. 3 November 2002

Editorial

The concept of "mental illness" is shuttling between the illness and the disability paradigm today. Various world agencies and policy documents made in the last couple of years reflect this paradigm shift. What are the implications, the costs and benefits, of this shift, at the level of concept as well as practise? Are users and sufferers choosing the disability language over the illness language?

In India, many carer groups have been pressing for recognition of the disability associated with having a psychiatric problem. We are talking in terms of "psychiatric disability". "Illness" has always been in terms of diagnostic classification and medicalisation. There is something remote and esoteric about classification. With "disability", there is the lingering hope that mental health will become more organically linked with community living and family life. Carers and community workers can talk more naturally in terms of common dysfunctions and impairments rather than symptoms. On the face of it, then, the term "disability" is more life-friendly as it has greater potential for integrating people with mental illness within the social context.

However, when we suffer from a psychiatric problem, do we think of ourselves as having a "disability". There is something long lasting about having a disability, and we like to hope that the psychiatric problem is transient, it is a phase, or it will go away. This is why we keep up our efforts for finding the right treatment. What do users feel about being disabled- There needs to be more discussion on this, as there is the risk of heightened paternalism. The other issue is of course the socio-economics of it. While the benefits accrued to carer groups are quite evident, what are the socio-economic benefits for the users themselves- This is not clear. Most users of psychiatric services are under guardian ship arrangements, either formally or informally, and have little recourse to such benefits. Involving users in the discussion is therefore of vital importance.

Psychiatric Disability

Contents

bapu
Trust for Research on Mind and Discourse

reflections

Yoga and Addiction

Sujata Venkatraman

I do not know of anyone who has not known addiction personally – through themselves or their friends and family. This strange empirical statistics occurred to me when in a conversation with a friend I noticed how difficult it really was to break the nicotine cycle. He had been smoking since his late teenage years and decades later, decided he needed to stop. It wasn't easy. He became a compulsive runner instead. Most of us have felt the compulsion of an early morning coffee without which we are dysfunctional for the greater part of the morning. Seemingly innocuous aperitifs and digestives consumed all over the world as part of meal routines can also lead to display of addictive tendencies of the population as a whole.

The cycle of dependency to drugs (nicotine, alcohol, opiates, depressants, hallucinogens etc.) begins with the first experiment of ingestion. The initial "buzz" is followed with desires for repetition and results in the creation of subtle habit patterns that becomes addiction. Constant substance use alters the structure of the brain and induces compulsive behaviour. There may be several reasons why people choose to experiment in the first place. These causes range from depression, anxiety, peer-pressure, wanting to increase energy levels, desire to explore other areas of consciousness or to explore or to even desire happiness. Whatever the reasons, the statistics of addiction is quite alarming. WHO estimates that every 1 in 3 people over the age of 15 smoke and alcoholism has spread to places where it didn't exist before. 90% of all suicides are related to substance abuse, depression or other mental disorders!

.....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

Center for Advocacy in Mental Health,
36 B, Ground Floor,
Jaladhara Housing Society,
583, Narayan Peth,
Pune 411 030
Tel: 0091-20-4451084
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. Write to us with all your suggestions, criticism and viewpoints on the issues covered.

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

Can we break this cycle of dependency? To be dependent on an external chemical implies constant craving. Can we recognize the symptoms of craving and obtain freedom from it? Contrary to most popular notions, addictions do not reflect the mental strength of the individual. An addiction or craving is compulsive. We must understand the nature of its origin to be able to avoid it. There are two basic issues : 1) Recognizing the seed of craving or addiction when a substance creates a habitual need and 2) Knowing fully well that addiction is deep-rooted and destructive. Most of us have very limited awareness of our body and its interactions with the mind. This creates the basic difficulty in identifying the first issue within us. Once the second issue comes up, our psychological fear and shame prevents us from seeking help.

Twenty five hundred years ago, Gautam Buddha recognized constant cravings and aversions as the root cause of human misery. The complex mind creates subtle habit patterns in the sub-conscious level, which makes us react to everything around us. Every attachment or aversion produces sensations within us. The body then becomes a huge reservoir of such sensations, which imprisons the mind into attaching a state of permanence to states of temporary existences. To seek freedom from this misery, Gautam Buddha introduced a very simple and elegant meditation technique that allowed one to be aware of their physical and mental states of being. This technique was one of self-observation and awareness. He asked his followers to observe everything that transpired within their bodies recognizing that every sensation was temporary and not permanent. This “mindful” meditation allows one to recognize the habit patterns created by the subconscious mind and break the endless chain of attachment and aversion it produces.

There are two prominent branches of Buddhism, Theravada (Hinayana) and Mahayana. Each one absorbed the basic technique taught by Buddha and developed it. In Japan, this meditation technique eventually became Zen Buddhism and in South East Asian countries such as Burma and Thailand, it became Vipassana. I would like to point out that although it is linked to Buddhist (hence religious) teachings, the techniques themselves are completely secular and can be practiced by anyone. This meditation only takes us close to our own mind and matter.

Vipassana meditation is an insight meditation, and literally means to see things as they really are. Practitioners learn the technique in ten-day residential courses, the aim of which is meditation with due observance of the eight-fold path first proposed by Gautam Buddha. Vipassana meditation courses begin with Aana-Pana meditation, where the meditator focuses his / her attention on the incoming and outgoing breath. This observation is objective – the meditator does not react to the patterns of breath or relate to it. Once the mind is made to increase its attentiveness, the students begin to observe the sensations produced in the nasal area due to the passage of incoming and outgoing breath. After a few days of practice when the focus and concentration is sufficiently developed, Vipassana meditation is introduced. The technique involves a careful study of the various sensations arising and passing away in the body, systematically starting from one extremity to the other and reversing the sense of observation at the end of each cycle. Observations must be made objectively: one must not react to the sensations he/she experiences with craving or aversion. By objective observations, without reacting to it, one gradually breaks the habit patterns generated in the sub-conscious mind.

It is the technique of self-observation that has enabled many of its practitioners to first identify their personal habits and addictive patterns. Objectivity in these observations also enabled them to realize that by not reacting to it they prevented a cyclic dependence on substance. As S.N.Goenka points out, “You have no addiction of drugs or alcohol. You have an addiction of body sensation. At the apparent level, yes, you are an addict. At the deeper level, you are addicted to your sensations”. Records indicate that people with addictions doing Vipassana are able to obtain complete recovery without relapse. It has been successfully introduced into Prisons such as the Tihar jail, India, North Rehabilitation Facility of King County Jail in Seattle, Washington,

North Rehabilitation facility, W.E. Donaldson correction facility in Birmingham, Alabama, various other prisons in U.S, U.K, Taiwan and India. Two videos give a very good description of Vipassana in prisons: “Doing Time, Doing Vipassana” is a documentary about the practice of the meditation in Tihar jail and “Changing from inside” documents Vipassana experience in the North Rehabilitation Facility. While the focus of both these documentaries is the transformation of the criminals, several inmates have claimed recovery from their addictions in these documentaries.

Zen like Vipassana is a meditation technique that emphasizes self-awareness and observation. Based on the same techniques taught by Buddha, the practice of Zen meditation differs slightly due to the influence of several great Japanese masters. Like Vipassana, it claims that attachments and cravings arise due to erroneous belief in permanence of sensations or events. In Zen, there is no “core self”, everything about the self is impermanent since we transform each moment, erase and create new sense of personal identity. Zen meditation revolves around “zazen” sessions, which involve brief twenty-minute periods or so of mindful, or awareness, meditation performed sitting and are followed by a walking meditation. In Awareness or mindful meditation, the practitioner observes the feelings within their body and remains aware of every passing sensation. While the observations need not be cyclic like Vipassana meditation, the entire focus is on the painful or pleasant sensations within the physical body. To help concentrate, one may observe respiration or count the inhalation and exhalation, experiencing it in its totality. The walking meditation or “Kinhin” allows people to move and stretch after a sitting period and is especially suited for people whose span of concentration is limited due to the effect of various chemicals. In Kinhin, practitioners learn to be aware of their feet, the effect of walking on their physical state and the effect of the external environment on them. They learn to be objectively aware of these effects on their physical body and learn not react to it. By not reacting to the external stimuli, practitioners do not feel the aggression associated with an unfavourable event or experience ebullient joy when they encounter something very pleasant. This enables them to understand pain, anger, joy, depression and other human emotions and to remain equanimous under all circumstances.

Excellent resource materials are also provided by former addicts who have used Zen meditation to help recover. Mel Ash’s “Zen of Recovery” is a recount of the author’s recovery from alcoholism using Zen meditation. He shows how it can be combined with another program such as the 12-step program of the Alcoholics Anonymous for efficacy. Bill Alexander’s “Cool Water: Alcoholism, Mindfulness and Ordinary Recovery” describes how simple mindful techniques of Zen provided him with an ordinary recovery from alcoholism. It allowed him to actualize the ordinary human life unfettered by cravings for alcohol.

Zen and Vipassana are not instantaneous solutions to the problem of addiction. Its efficacy is not immediate. The greatest advantage it offers is that the person assumes responsibility for their life and through awareness gains an understanding of both the existence and the nature of their addiction. Often times the meditation sessions might themselves bring to forefront painful memories and emotional disturbances. The discipline in both these techniques can come in handy during such times. Determination and social support from the people around can also ensure constancy of practice. Awareness is the first step to higher consciousness. Meditation techniques such as these allow one to live in a constant plane of well being without having to shuttle back and forth between the highs and lows associated with addiction. Ultimately each person will need to decide this question for himself or herself.

✧ ✧ ✧

The right to rehabilitation is a fundamental right, claim advocates

A one-day workshop on "Right to Rehabilitation for Persons with mental illness", was organised on Saturday 24th August 2002, at the Indian Social Institute, New Delhi, in memory of the victims of the Erwadi tragedy last year. Deepika Nair of RASHMI and her colleagues from New Delhi, along with Amita Dhanda of bapu Trust, organised the workshop, continuing bapu's interest in facilitating legal activism in mental health. It was considered appropriate to organise the workshop independently of the Mental Health Week, which was soon to follow, as the deprivations associated with living with mental illness needed a separate advocacy platform.

The workshop had the objective of giving content to the concept of "rehabilitation". The human rights issue in mental health is not just about ensuring removal of chains, or having clean and functional toilets. It is about what happens to the lives and individual aspirations of institutionalised people and people living with mental illness. The diversity of interests among change agents in the Mental health sector- professionals, users, consumer groups, carers, and NGOs- were addressed at the workshop. Various NGOs, lawyers, activists, users, carers, clinical psychologists, government functionaries, psychiatrists and doctors were present at the workshop.

Sujata Manohar, erstwhile Chief Justice of the Kerala High Court and member of NHRC spoke about the NHRC initiatives. She spoke about the rigid social mindset, which makes it very difficult to ensure that human rights of people be respected. Even within institutions, the conditions are often horrifying. There are many states (Rajasthan, Tamil Nadu, Sikkim, Delhi, West Bengal, Jammu and Kashmir, Karnataka, Manipur, Assam and Orissa), which keep the mentally ill chained within prisons even today. Mental hospitals also have jail-like structures including high walls and barred windows, to protect society from the inmates. However they provide little protection for those who are supposed to benefit, as can be seen from a number of pregnancies, which take place there, clearly indicating the sexual exploitation of residents.

Human rights will be respected only if self-care and self determination are recognized as important values for users of mental health services. When one admits to feeling mentally unwell, everyone automatically robs one of the autonomy to make personal choices or decisions. This over-protection eliminates the user's role in self-care. Medications hardly provide one with the required time for self-introspection and healing. In practice, prescriptions, side effects, etc. are never talked about with the user. Psychiatrists often also connive with pharmaceutical companies to prescribe only those drugs for which they receive an incentive. There is no rational drug therapy in psychiatry. ECT should also have a law regulating its indiscriminate practice. Psychiatrists never make appropriate referrals (to clinical psychologists, for example) and claim expertise in areas where they have none (therapy or counselling). The backbone of the medico-legal system in mental health is about defining mental illness on the basis of concepts of "danger to self and the society", "being unfit", "incompetent", "not having capacity" and so on. There has to be guidelines created about determination of mental illness in medico-legal contexts. Often it is left to subjective whims and fancies of psychiatrists called upon to certify. Such bad practices must be thwarted with necessary litigation.

From the carer's point of view, many positive improvements have taken place in the last decade. But a lot still remains to be achieved. More often than not, families are left to fend for themselves on multiple fronts. Social isolation, lack of awareness, feelings of inadequacy, avoidance, etc. characterise society's response. Loss of self-confidence and esteem, dependence (economic, social and psychological), loneliness, isolation, confusion, feelings of incompetence and hopelessness - these may characterise the life situation of a relative living with mental illness. In these cases, making a balance between protection and overprotection becomes complicated, because you see the obvious need for care and support. Most families also need to deal with the extreme medicalisation of rehabilitation, and the non-communication between professionals and carers. It is a good thing that today, we have a policy whereby doctors are forced to record every prescription and reasons for increasing medication. There are doctors who first ask

the family to go to the ECT room for a dose, even before having a consultation. Often rehabilitation is center-based, when it should be community based. Building capacity among the users towards self-care, increasing their threshold for management, dealing with fears and apprehensions and decision making, transfer of skills to the home situation, etc. need to be addressed along with vocational skills. Carers too need help to manage the illness more effectively for which their judgement about when to let go and when to protect becomes very important. A course on psychotherapy is desperately needed. Carers' fear of relapse, crisis management, managing medication and individual needs must be addressed more meaningfully, instead of with subjective, vague symptomatic instructions.

The law only speaks about the deprivation of rights that a person with a sound mind may have otherwise had recourse to, such as not being able to enter into legal contracts. The law doesn't have a regime of positive rights for persons with mental illness within society. The Indian constitution speaks about right to dignity. It is worthwhile to think about how this right to dignity, self-determination, participation and informed choice can be translated into a legal reality. Unlike the Mental Health Act, which is simply about involuntary commitment, the disability act is the first major legislative acknowledgement of the fact that mental illness and a capacity to act can subsist together. It talks of empowering the disabled, non-discrimination, social security and the right to rehabilitation. There must also be a Rehabilitation Act, which promises clear positive rights and protection. There are two voices of the law; one of deprivation and one of empowerment. We have to make it our task to make the latter one the more dominant and the former the exception The latter has to happen only when it is absolutely necessary and only for the amount of time for which it is strictly necessary. Carers also have a big role to play in this, which they must utilise more fully. There must be greater application of mind in making and using the law, which should protect the most vulnerable, not the most powerful. For example, if divorce should be granted on the grounds of mental illness for one partner, then maintenance and other packages of financial support should also be available to the patient as a part of the same nullification. What you have is only nullification without safeguards. In rehabilitation "incapacity" must be replaced with "reasonable adjustment".

Community based rehabilitation is an important step in mental health today, but it lacks sustainability in many cases, as they are program or projects based. This has been taken into consideration by an organisation in Bangalore known as Humanitarian Hands, which essentially picks up vagrant and wandering mentally ill persons of the streets. CBR (Community based rehabilitation) covers all aspects of individual, family and community, keeping the gap between users and service-providers very clearly in mind. On the individual basis, the question of availability of medication does arise. One still finds cases of persons being administered traditional neuroleptics, which have very serious side effects. Also, sometimes, no matter what the level of disability, the family wants the person to contribute to income-generation in one way or other. Supportive therapy and coping skills are also very important since one tends to loose focus on this many a times. Users may sometimes be so overwhelmed by the trauma of severe mental illness, that they may lose self realisation in the recovery phase. Infact, many users attempt suicide, not in the ill phase, but in the recovery phase. Also, the gender aspects of rehabilitation needs more attention. Families do want to know the difference between "symptom" and "normal" behaviour, and their threshold for tolerating behaviour may be extreme. Building creativity within institutions is an important rehabilitation task, which is sadly missing today. Doctors and organisations, which practice exclusion of acutely sick patients, must be sensitised and taught new skills in crisis management. Community-based rehabilitation is a value-based partnership between mental health professionals and users.

The joint secretary from the woman and child department announced the scheme of "Swadhaar", under which various categories of women would be covered. This includes the category of mental health. The Indian Psychiatric Society initiative on IDEAS was shared. The therapeutic community approach of the RFI and the role of family therapy in rehabilitation were outlined.

✧ ✧ ✧

Advocacy for mental health linkages in RH

Sonali Wayal

Gender stereotypes, reflecting societal norms and imperatives underline the popular understanding of health as well as illness. This has had tremendous impact on the lives of the women, especially their reproductive health. Besides a look at the various national and international agendas clearly convey the narrow approach towards reproductive health. They have primarily linked it to fertility and population growth rates. Due to this limited focus the reproductive health policies have become tools, used by the State and the market, to dictate, control and medicalize the bodies of women. It is only recently that gender equity and women's reproductive rights and health have found a mention in these policies.

After the 1994 International Conference on Population and Development, the World Health Organisation has defined reproductive health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes." Irrespective of this global shift, the various reproductive health policies revolve around maternal and childcare and lately infections, in the back drop of the increasing rate of deaths due to HIV/AIDS. The other aspects related to reproductive health like menstruation, issues related to sexuality, infertility etc. remain unattended even today. In this background the total negligence of mental health component of reproductive health can be easily understood, though not justified. This is true of both mainstream work as well as advocacy in reproductive health.

The intersection between reproductive health and emotional and mental well being of a woman is considerable in scope. It is important to recognise and describe the psychiatric and psychological syndromes linked to reproductive health. These include various issues like menstruation, abortion, stillbirth, miscarriage, post-partum depression, infertility, menopause, rape, domestic violence and other gynaecological morbidities like reproductive tract infections etc. But the literature, being produced in this arena, is purely psychiatric and it has its own limitations. It does not address women's experiences about body, sexuality and reproductive health in a holistic manner. The impact of the socio-economic conditions, culture, gender, interpersonal relationships of the woman is often not addressed. There is tremendous under-recognition of these experiences and conditions by the health professionals as well as by the society at large. This breeds a "culture of silence" amongst the women forcing them to accept their ailments either as "normal" or "abnormal". Women usually bear ailments like pre-menstrual stress or other gynaecological morbidities mutely as they are socialised to accept these as a part of being a "woman" and thus "normal". On the other hand if a woman expresses her inability to cope with the demands of mothering she is looked at as "abnormal" and the condition is termed as a pathological condition.

The lack of consideration of the experiences of women affects their help seeking behaviour and hence it is crucial to understand the inner world of the women. Research directed towards understanding the linkages between reproductive health and mental or emotional well being of the women, from the women's perspective, will have positive implications for framing gender sensitive policies and programmes. It will provide insight about the feasibility of integrating mental health aspects into the public health discourse as well.

Sonali Wayal, working on the linkages between reproductive health and mental health, can be contacted sonaliwayal@yahoo.com

✧ ✧ ✧

IDEAS for Measuring Disability- The IPS takes initiative

At the "Right to Rehabilitation" workshop held in Delhi on August 24th, Dr R Thara (from SCARF) shared news about IDEAS, a tool for measuring psychiatric disability, developed by the Indian Psychiatric Society & SCARF, and accepted by the Central Government recently (Gazette of India, February 27,2002 (No.49) Notified by Ministry of Social Justice and empowerment).

Disability may be defined as a "difficulty in the performance of roles expected of the individual in his or her social and cultural milieu". Disability caused by mental illness is often invisible, unrecognized or ignored because of its variability, and there have been issues about measurements, making the implementation of the PWDA difficult. Earlier, professionals believed that prognosis can be made from clinical and diagnostic studies. However, this has proved to be a false hope. Valid measures of psychiatric disability are needed to understand patient prognosis, utilization, length and outcome of hospitalization, monitoring patient care, quality of care, improving treatments, social integration, rehabilitation and finally, improving policy and program planning: Welfare benefits, Insurance, etc.

Disability may traverse through three different dimensions: restriction, a limitation and then, an impairment. When we talk about impairment, this may be at the body or mental level, society, activities or participation. Dr. Thara shared news about other disability measurement tools in India, such as the Dysfunctional Analysis Questionnaire, the Schedule for Assessment of Psychiatric Disability, the SCARF social functioning index and the ICIDH. ICIDH is a system developed to describe, define, measure and classify the state of functioning (or disability to function) associated with health conditions(ie a disease, disorder, trauma or other health-related states).

Dr Thara explained that psychiatric disability, conceptually, is not linked with etiology. The diagnostic classification is put to use for the development of more rational interventions. The concept is useful for developing frameworks in cross cultural contexts, and also, it is now possible to link up disability with the civil rights movement. The ICIDH tool covers body functions, body structure, activity, participation and environmental factors. However, the ICIDH may be too sophisticated to be used at all levels of the public health system.

Dr Thara noted that the inclusion of mental illness in the Persons with Disability Act of 1995 is a landmark milestone in policy. The IPS was invited to develop a tool, which has now been accepted by the central Government, called IDEAS. The tool is simple and easy to administer, it covers all critical disability areas, it can generate scores, it is comparable to other disability measurements and it is sensitive to change. IDEAS covers the following dimensions of disability:

1. *Self Care* : Personal hygiene, eating habits, personal belongings, living space.

2. Interpersonal activities : form and maintain social relationships, emotional response, physical intimacy etc.

3.Communication and understanding: spoken and written language, ability to converse, use of communication devices.

*4.*Work *:* Employment, house work, student regularity and competence at work. The diagnostic categories covered by the tool are schizophrenia, Bipolar illness, dementia and obsessive compulsive disorder. As a cut off limit, the duration of the illness should be at least two years. IDEAS can be used by social workers, psychologists or occupational therapists. Dr Thara noted that between 20-70% of people with mental disorders suffer different levels of disabilities. Dr Thara then listed the implications for rehabilitation. She noted that the rehabilitation needs of people disabled by mental disorders differs from others. Rehabilitation needs differ by age, gender and domain of disability, and so it is possible to give individualized care.

The IPS initiative with respect to Disability must be appreciated. However, there are many notions widely used within the medico-legal and policy context of mental illness which needs such standardisation. These concepts include "capacity", "unfit to work", "capacity to consent", "dangerous to self and society", etc. We hope that the IPS and other such professional bodies will standardize these concepts as well. A curious lack in this initiative has of course been the lack of involvement of carer or user groups. Perhaps in future such initiatives, the IPS will give a greater role for these groups.

The disease status of ADHD is questionable, rules RCC (Holland)- CCHR reports

On 11th August 2002, Citizen's Commission on Human Rights International, LA, USA, put out a notice on false claims made regarding ADHD (Attention Deficity Hyperactivity Disorder). The notice followed multiple efforts by CCHR to give visibility to the abuse of children within the psychiatric service system in the US.

In its decision handed down on August 6th, the Netherlands Advertisement Code Commission (Reclame Code Commissie) ruled that the country's Brain Foundation cannot claim that the controversial psychiatric condition Attention Deficit Hyperactivity Disorder (ADHD) is a neurobiological disease or brain dysfunction. The Commission ordered the Brain Foundation to cease such false claims in their advertising. The Advertisement Code Commission was responding to a complaint brought by the Dutch chapter of the CCHR, an international psychiatric watchdog organization.

The Advertisement Code Commission found that the Brain Foundation had falsely advertised and solicited funding by publishing ads in newspapers, magazines, flyers and on TV that stated ADHD is an "inherent brain dysfunction." The Advertisement Code Commission decision stated, "The information that the defendant presented gives no grounds for the definitive statement that ADHD is an inherent brain dysfunction. Under the circumstances, the defendant has not been careful enough and the advertisement is misleading." The decision has prompted calls for similar orders to be made in the U.S. Ms. Jan Eastgate, President of CCHR International, stated, "Fraudulent claims that ADHD is neurobiological must stop. We have already filed a similar complaint in the United States. Child Psychiatrists are put on notice that we will continue to file complaints and / or bring legal action as necessary against false and misleading claims". In the US, and elsewhere, several mental health professionals are successfully treating problems among children by addressing their nutritional deficiencies, against the tide of an increasingly aggressive processed food industry which is destroying any notion of holistic health among children. More information on the plight of millions of children subjected to mind-altering psychiatric drugs can be found at CCHR's website http://www.fightforkids.com. For alternative approaches to treating ADHD, visit www.alternativementalhealth.com and its links.

Expert opinion

We asked a mental health expert, Nandita de Souza from Sangath Center, Goa, to respond to the RCC ruling on ADHD. Here is her response:

"People in the West are becoming increasingly concerned about the growing (and often exclusive) use of medication to treat behavioral conditions. There has been quite a bit of research linking dopamine gene loci (notably DRD3, DRD4, DBH and DAT1) to ADHD. However no conclusive evidence has been demonstrated. However it appears to me that the main issue here is not the diagnosis, but the treatment -where increasingly, if one is labeled with a psychiatric condition, then inevitably, a drug will be used as the next step. I also believe that ADHD is under-diagnosed in India, but unfortunately, I would say that, at least in the cities, where the psychiatrists are, the first mode of management is drugs, without an adequate trial of behavior modification, educational inputs etc. Thus with the way things are going now, I think that the situation in India will soon be very much like that in the West. A recent excellent article by Peter Hill & Eric Taylor (Arch Dis Child 2001:84:404-409) on an auditable protocol to be followed while managing ADHD recommends drug therapy only after a trial of behavior modification. There is an urgent need for mental health doctors to learn more about (and thereby recommend) non-drug therapies too."

Psychiatric Disability in the UN Disability Convention

Ms Tina Minkowitz represented the World Network of Users and Survivors of Psychiatry at the meetings of UN Disability convention. Her report for the Quadrennial review of the implementation of the World Programme of Action on Disability has been widely circulated through user networks all over the world. She and others involved in this initiative have called for world users to participate more actively in influencing the UN to attend closely to the rights of psychiatric survivors. Her report represents the views and opinions of various organizations and individuals around the world, including, Janet Amegatcher, attorney from Women in Law and Development (Africa), Janice Campbell (ECT survivor and activist), Sylvia Caras (peoplewho.org), Bhargavi Davar (Center for Advocacy in Mental Health, Pune), Mr. Sci. Reima Ana Maglalic (BiH, Bosnia & Herzegovina), Cully Downer (UK), Eric Rosenthal (MDRI), Mari Yamamoto (Japan National Group of Mentally Disabled People) and Laura Ziegler (activist, US). Here sections of the report on ECT practice and the situation in India are published. For the full report write to Tina Minkowitz (See her special report in this issue).

"In India, people labeled with psychiatric disability lose their civil rights to marriage, contracting, holding public office, and asset management. For this reason, it is left to guardians to apply for government disability benefits on the person's behalf, and often it is done for the benefit of the family rather than the person her/himself.

"The involuntary commitment Act (Mental Health Act, 1987) regulates admission and discharge from mental hospitals, but says nothing at all about disability and the fundamental right to rehabilitation / reintegration into mainstream society. Because of this, people incarcerated live and perish in the hospitals with no accountability from the system. Addressal of individual problems are left to personal initiative of the hospital chief or some local NGO, but not mandated by law.

"Advocacy points [in India] have been the following:

- recognize right to rehabilitation as a fundamental / constitutional right
- implement the persons with disability act with respect to psychiatric disability also
- reform all laws in keeping with values of self determination, justice and autonomy instead of welfarism and paternalism
- respect international instruments."

"The use of electroshock (ECT) is increasing in many regions of the world. This is alarming because there is evidence that ECT causes brain damage and often-severe permanent memory loss and cognitive impairment. An unconfirmed report stated that ECT is being widely used in Afghanistan because they had nothing else to offer the many women and men suffering from depression in the wake of the traumas that country has suffered.

"Forced electroshock is widespread in India. ECT is often the first line of treatment chosen by many doctors, as they can make money out of it. In India, there is no regulation whatsoever of the practice. ECT is often administered in private clinics, without anesthesia (what is called 'direct ECT'). The professionals, some of them, even justify this saying that it may not always be possible to organize anesthesia facilities in a poor country. In many clinical settings, doctors unreservedly prescribe ECT without heeding to any norms (when, how often, reviewing, consent, etc.). The issue of consent is rarely looked into because of the predominant surrogate decision making.

"In Japan, electroshock has been revived over the past decade, over the objections of the user/survivor movement. The Japanese Municipal Hospital Association (an association of public hospitals) found that electroshock is most often used "unmodified"– so that although people may be put to "sleep" first (with an injection of barbiturate) they experience bodily

convulsions. Sometimes the ECT is done without even putting the person to "sleep" first. Only 35% of ECT is done with informed consent, and there is no legal protection for the right to refuse.

"A leading activist in the user/survivor movement reports, "In Japan there are only a few anesthetists, and most mental hospitals cannot get them or pay for them. Besides this, ECT is often given to punish patients and in such cases there is no time to prepare for anesthesia". A leading newspaper reported that in Matsuzawa Hospital, run by Tokyo local government, with 1368 beds, there were some 2000 electroshocks done in the year 2000, 1750 of which were done without general anesthesia, with body convulsions and only an injection of barbiturate. The newspaper also found that most ECTs were without informed consent and that ECT was overused to punish patients. This publicity spurred the report of the Municipal Hospital Association.

"Similarly to the situation in India, there is no regulation of the practice, and surrogate decision-making is predominant. Over 80% of the beds in Japan are in private hospitals and the public ones are relatively better for patients' rights. Therefore it is believed that the statistics for informed consent quoted above are even lower in the private hospitals.

"In the US, the American Psychiatric Association has removed a prohibition on using ECT for behavior control from its revised guidelines on ECT. Statistics in one US state show a 125% increase in applications for court-ordered electroshock since 1997. Another report in the same state shows that electroshock is used primarily on women (confirming other reports with the same finding), and that controlling behavior is considered acceptable as a justification for its use. The draft UK Mental Health Act authorizes use of ECT for reasons including behavior control. While a few US states have passed laws restricting the use of ECT, especially on minors, this is not the norm. However, it has been reported that Italy has "nearly abolished" electroshock by directive of the Minister of Health, and that it is nearly obsolete in Germany and Holland, as well as Slovenia."

"People labeled with mental illness have often been overlooked or spoken for by others, when it comes to human rights. We believe that a Convention on Disability which respects all human rights, and protects the right to live as a person with a disability or as a person perceived to have a disability, will be of great value to us in asserting our rights. We also welcome the opportunity to collaborate with DESA, the Special Rapporteur on Disability, and other UN mechanisms such as the Office of the High Commissioner of Human Rights and the treaty-monitoring bodies."

✧ ✧ ✧

bapu archives

I bury my head in my lap
Alone,
I cry...
So depressed
Why?
I don't know...
I just had a baby
I should be happy
Shouldn't I?

Waiting,
for someone
to help the pain...
He called the doctor.

Now
I wake up
in a cold grey world.
My head hurts,
Where am I...?
My brains feel crushed
imprisoned in my body
What happened?
"Shock treatment"
A woman says
Peering behind steel grey eyes...

Poem by Vikki Grant
Madness Network News,
Summer 1982 Vol 6, Issue No. 5

Towards the UN Disability Convention, 2003

By Tina Minkowitz

The author represented World Network of Users and Survivors of Psychiatry at the recent meeting held at the UN of an "ad hoc committee" of the General Assembly to begin negotiations of the UN Disability Convention. Work is going on in the inter-sessional period to further clarify our positions and advocacy on key issues, and another meeting will be held at UN headquarters in NY in May 2003. The meetings of the ad hoc committee are open to the participation of non-governmental organizations, and you do not need to be already accredited with the UN to join. For more information about participation, see http://www.un.org/esa/socdev/enable/rights/adhocngos.htm

The United Nations is negotiating a treaty on the rights of people with disabilities ("Disability Convention," more fully a "Comprehensive and Integral Convention to Protect and Promote the Rights and Dignity of Persons with Disabilities"). This treaty will join the other major human rights treaties, such as the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, the International Convention for the Elimination of Racial Discrimination, the Convention for the Elimination of all forms of Discrimination Against Women, and the Convention on the Rights of the Child.

As survivors of psychiatric assault, we have an opportunity to influence this treaty and educate the world about the human rights violations we face. These violations, as you know, range from deprivation of civil liberties such as voting, to the terrifying experiences of incarceration, restraint and seclusion, forced drugging and electroshock. Also, because of discrimination and because the vast majority of us live in poverty we are vulnerable to having intolerable conditions imposed on us when we seek to meet our needs for housing, employment, income assistance, or voluntary mental health treatment. Often people suffer from deprivation of their basic needs.

The problem has been, in part, that because of the usefulness of psychiatry and its tools of repression to governments, the power of the psychiatric industry, and social attitudes equating madness with defect of character and subhuman status, human rights law has not been interpreted to include us. For example, the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, and the Torture Convention (plus regional conventions) make the prohibition against torture absolute ("non-derogable"). The definitions of torture appear to include forced drugging and electroshock, particularly the definition used in the Inter-American Convention to Prevent and Punish Torture, which prohibits the use of methods designed to obliterate the personality of the victim or to diminish his or her mental or physical capacities. We know that neuroleptics and electroshock "work" the way psychiatrists want them to by slow or fast brain damage, which creates psychic apathy and deprives the person of the ability to act spontaneously or creatively. This is seen especially in the use of neuroleptics and electroshock as restraint or in order to control behavior. A substance or procedure that works on the brain cannot control behavior otherwise than by diminishing the person's mental capacity to act. There is some thought in the literature on torture that medical treatment justifies actions, which would otherwise be torture, but I think it can be shown that this de-values the individual and her uniqueness, which is a core value of human rights law.

The opportunity that we have with the Disability Convention is to put forward our issues in a context where we are seen as the experts on our own experience. The Disability Rights movement says "Nothing About Us, Without Us!" and means it. To argue for recognition of our humanity as fully equal to that of other people, is a powerful vision that we share with the disability rights movement. The question

arises whether we are disabled or only socially devalued. I would argue that the philosophy of the disability rights movement, that disability is a social construct, gives us room to present our issues as we choose.

We also need to consider that the Disability Convention will likely purport to include us whether or not we take an active role in framing it. "Mental illness" was already included in the UN's Standard Rules on the Equalization of Opportunities for Persons with Disabilities among types of impairments or conditions that give rise to disability. So our movement has to take some position about it. The approach of World Network of Users and Survivors of Psychiatry (WNUSP) so far has been two-fold – to raise consciousness by fighting for our core issues to be included, and to minimize the harm that can be done by ignorant or misleading language that could be used against us. I am interested in hearing other points of view, and very much welcome dialogue about any issues regarding the convention or the use of human rights law and principles to stop psychiatric assault. You can contact me at tminkowitz@earthlink.net or at the address below.

Tina Minkowitz, J.D.

91 Bradley Avenue

Staten Island, NY 10314

USA

For more information about the Disability Convention and the work of the ad hoc committee, see http://www.un.org/esa/socdev/enable/rights/adhoccom.htm and http://www.sre.gob.mx/discapacidad/home.htm

Announcement from Safe Harbor:

Safe Harbor has created an email list called Integrative Psychiatry for healthcare practitioners interested in sharing information on holistic mental health treatments. To join the list, send an email to: SafeHarborProj@aol.com

More reports of lesbian suicides

The last decade has seen many despairing lesbian couples driven to suicide. On October 4th, the bodies of Geethalakshmi (27yrs) and Sumathi (26yrs), two women from Kallipatti and Chennai in Tamil Nadu, were discovered and reported. They committed suicide on September 28, by consuming poison in the Satyamangalam forest area, Erode district. Geethalakshmi and Sumathi were living together in a yoga center in Coimbatore but were separated when the guru of the center discovered their relationship and threw them out. They returned to their respective homes but felt there was no respite because they would have to get married eventually. Sumathi and Geethalakshmi left notes for their families admitting to their love. Their last wish to be buried or cremated together was respected by their parents.

OLAVA (Organised Lesbian Alliance for Visibility and Action), Pune, along with friends, supporters and students met on Thursday, October 17, 5pm in Pune city to mourn the loss of these young womens' lives. The meeting started with a briefing and a remembrance of some of the other suicides in recent years. All those present observed a minute's silence and then lit candles. Letters of solidarity were read and shared. There was a discussion on how homophobia operates in our society and what we can do to prevent these suicides from taking place.

Amongst these continuing suicides, what is the role of mental health professionals? We have heard of ECT being given for "curing" homosexuality, and other gruesome techniques. Even psychotherapy, given from a biased perspective, has caused a lot of pain and anguish for homosexual men and women. The bias went out of the diagnostic text books at least 20 years ago, but it has been difficult to take it out of practice. Users must continue to resist and fight inhuman practices within the mental health system against sexual minorities.

Press release from OLAVA

We, at OLAVA, are deeply disturbed at the loss of Geethalakshmi and Sumathi's lives. This incident highlights the lack of spaces and support for women who love women in India. The suicide of Geethalakshmi and Sumathi is one of the many lesbian suicides that have occurred over the last decade: two nurses in Meghraj, Gujarat, killed themselves in the local hospital quarters because they were to be separated by forced marriage; two young women who worked at a shrimp factory committed suicide on a railway track near Tiruvalla, Kerala, after their separation was imminent; another young couple from Ernakulam, Kerala, tied themselves with a dupatta and took their lives by jumping into a granite quarry after their failed attempt to elope with each other. Many of the suicides go undocumented or unreported or are not understood as lesbian suicides.

We at OLAVA feel it is necessary for all individuals to introspect and identify the homophobic biases that have been cultivated within us. In a male dominated, heterosexual society it is easy for us to believe that heterosexuality is the only way to be and that any other practice or identity is necessarily deviant or filthy. It is this belief that creates hatred for homosexuality and gives the message that it is wrong and undesirable. This hatred is sometimes also internalised by women who love women.

The fact that Sumathi and Geethalakshmi were thrown out of the ashram and separated because they were guilty of love bears testimony to this. These women had no access to any other groups or individuals who could understand their situation and offer them help. In fact, they felt their situation was so hopeless that they did not even try to approach their families, who did not know about their relationship until after Sumathi and Geethalakshmi took their lives. How many more women must die before we stop and realise how dangerous and violent homophobia is? Homophobia affects women who love women in many different ways: when there is hostility from within the family women have faced involuntary confinement, torture, isolation, threats, and even death. There have been incidents where even when the family is supportive, conditions in the workplace have become dangerous when people "found out". Such as the case of two young women from the Special Armed Forces who were confined without food for 48 hours, forcibly physically examined for signs of an apparent sex change, discharged from service and left at the railway station in the middle of the night when their superiors found out that they were living as a couple.

We send our condolences to Sumathi and Geethalaksmi's family and friends and hope that we can start the process of making serious changes in the way we look at sexuality. If you are a woman who loves another woman, are questioning your sexuality or simply want more information, contact us at olava_2000@yahoo.com or at P.O. Box 2108, Model Colony Box Office, Pune 16.

Dear *Aaina,*

This is to say how much I enjoyed reading the latest issue of Aaina. I am placing a copy in our department library and have made it mandatory reading for our students. Some say they are confused because it is so much at odds with what they study in the classroom, but I suppose confusion is the first step towards critical thinking. Some said they did not know ECT was 'so bad'. Advocacy issues are totally missing in our curriculum, I am so glad there is some material for all of us to read and to reflect. You are really doing a stupendous job, all the power and resources to you and your team.

Dr U. Vindhya,
Department of Psychology, Andhra University
Vishakapatnam, AP
vindhyau@hotmail.com

Time Out of Mind

Eric Shapiro

Let us first consider the role of time in our lives, then let us consider that role in terms of mental illness. Buddhists and Hindus, among others, propose that time does not actually exist. The Western world, however, with its dependence on clocks and deadlines, scoffs at such a notion, relying upon sayings such as "Time is money" and "Time is of the essence."

Time is of the essence. What an expression. Its inherent suggestion is that time comes from our essences; time exists within our souls. This is consistent with the Western position that time was discovered rather than created. Then again, the question haunts us: what if we did, in fact, create time? What if all our ticking clocks and watches amount to nothing more than a symbolic quest for orderly and coherent living? It's a terrifying yet convincing idea.

One considers, then, how time functions from the perspective of a person with a mental disorder. The sufferer of depression, or anxiety, or psychotic ailments, likely travels life's trajectory in creaky slow-motion. Catchy sayings such as "Life's too short" make such victims grin wearily, responding in their minds, "No, life's too long." Given the incessant presence of pain in the victim's mind— the ceaseless worrying, excessive self-reflection, and troubling sensory distortion— hours tend to stretch, stretch, stretch until the act of exiting one's bed in the morning becomes overwhelming.

Another kind of smile, likely even more weary, will cross the sufferer's face when met with this maxim: "Time flies when you're having fun." Indeed it does, and indeed the patient's schedule leaves no room for fun of any kind. Unless, of course, one counts the quiet joy of the moment when the depressed person sees that it's already six o'clock and thinks, "I can't believe I've made it another hour."

It is this writer's suggestion that given the dark relationship between the aching mind and the ticking clock, the mentally ill should ignore time altogether. Take a note from our Eastern thinkers and do not, as my father always told me, "try to live the whole future in one day." Again, time needn't be regarded as a finite fact of life. One may choose to doubt it, or, moreover, disapprove of it! Who needs time, anyway? Whose mind needs a sweltering flurry of images from a thousand yesterdays and ten thousand tomorrows?

The path to wellness may take two months or it may take two years. This is of no consequence. The moment is of the essence.

Eric Shapiro is the author of SHORT OF A PICNIC, new this fall from Be-Mused Publications.

✧ ✧ ✧

Resources on Yoga and addictions

sourced by Sujata Venkatraman

1. Bill Alexander, *Cool Water: Alcoholism, Mindfulness and Ordinary recovery,* Shambala publications
2. Mel Ash, *Zen of Recovery,* J.P.Tarcher
3. Mary Heath, *The Benefits of Zen Meditation in Addiction and Recovery,* www.viacorp.com/addiction.html
4. John Welwood, *Toward a psychology of awakening,* Shambala Publications
5. Alan Watts, *The way of Zen,*Vintage books
6. Doing Time, Doing Vipassana, by Karuna Films, published by Vipassana Research Publications
7. Changing from Inside, by David Donnenfield, published by Vipassana Research Publications
8. S.N.Goenka, *The art of Living,* Vipassana Research Publications
9. Lance M. Dodes, *The Heart of Addiction: A New Approach to Understanding and Managing Alcoholism and Other Addictive Behaviors,* Harper Collins
10. Joan Tollifson, *BARE-BONES MEDITATION: Waking Up from the Story of My Life,* Bell Tower/Random House 1996

The amicus curiae's note to the SC in Writ petition relating to death of inmates in Erwadi and Saarthak- A report

In their recent response to the SC, the amicus curiae reiterated that their endeavour is to ensure that there are adequate mental health care facilities available in the country, the laws are amended and made in tune with the changing medical and social conditions, the mentally ill patients are treated humanely and by licenced institutions, the conditions of licence are in accordance with the need assessment survey of every State and that there is adequate social security mechanism devised for mentally ill patients.

Justice PC Mullick dealt with certain aspects of Mental Health law that have functional application for psychiatrists and psychiatric hospitals and nursing homes. He also raised certain issues that need to be deliberated upon. He noted that from 1912 Mental Health in India was governed by Indian Lunary Act, 1912. This was repealed and replaced by the Mental health Act, 1987. The first aspect he traversed is that of *registration or licence*. Section 6 of the Mental Health Act mandates that no person shall establish or maintain a psychiatric hospital or psychiatric nursing home unless he holds a valid licence granted to him under the Act. Only psychiatric hospitals or psychiatric nursing homes established or maintained by the Central Government or any State Government are exempted from licensing, psychiatric hospitals and psychiatric nursing homes include convalescence homes as per the licence. As regards De-addiction Centres, in his opinion, the pith and substance has to be seen. If the centre is primarily catering to medicinal and rehabilitative treatment of drug addicts, it may not fall within the definition of the psychiatric hospital or nursing home. But if a body is denied licence to function as a psychiatric hospital or psychiatric nursing home but to evade the law masquerades as a de-addiction centre, it cannot be allowed to function without a licence. According to the hon. Judge, since drug addition is itself a psychiatric problem, and psychiatric treatment of drug addicts is necessary, the Mental Health Act ought to be suitably amended to bring these centres within its fold. He has made this suggestion to the Supreme Court in the case of death of 25 chained inmates in Mental Asylum Fire in Tamil Nadu. Union of India has filed its response in July 2002 stating that it is appointing an Expert Group to formulate norms for NGOs and also to suggest amendments to the existing rules if necessary. The Expert Committee is expected to give its recommendations in six months time from the date of its constitution. The proper course, in the AC's opinion, is that all bodies, by whatsoever name called, purporting to offer psychiatric care services, should be registered and norms should be framed for them.

The hon. Judge first dealt with the vexed issue of proliferation of unregistered bodies, which he came across while dealing with the case relating to death of 25 chained inmates in Mental Asylum fire in Tamil Nadu. The village at Erwadi has a Dargah and it is popularly believed that mentally ill persons if taken to the Dargah during Friday prayers and given holy water, would be cured of their malaise. As more people started bringing in their mentally ill relatives, several so-called asylums sprung up around the Dargah. These so-called asylums charged a fee for confining the mentally ill persons, feeding them and taking them to the dargahs. About 16 of these asylums came up capable of housing about 1000 people. Inside these asylums the inmates were kept chained to their beds. On the morning of 16.8.2001 a fire engulfed one of the cottages and 25 chained inmates were burnt alive, 11 of them women. 3 persons later succumbed to injury, taking the toll to 28. The Supreme Court took suo motu cognizance of the matter and issued notices to the Union of India and State of Tamil Nadu. Adv Mullick and Dr. A.M. Singhvi were appointed Amicus Curaie by the Supreme Court to assist the court in the matter.

In dealing with this case, the advocates came across the problem of unlicensed and unregistered bodies catering to mentally ill persons. Many of these, like Erwadi, were religious bodies. In their opinion, at times even educated people go to religious places, ojhas, pirs and fakirs for psychiatric problems, instead of to the doctors. At some of these places, for e.g. in Rajasthan, the cure includes placing heavy stones on the belly of the patients, in Kerala it is flogging the patient. In their opinion, there is no check on the manner of treatment let alone the conditions prevalent, sanitation, care or protection of human rights. In Erwadi itself, in April 2000, 8 inmates of two homes had died due to severe diorrhea, but the District Administration after making a pretense of inspection, did nothing whatsoever and allowed the homes to function in the same manner, ultimately culminating in the 16.8.2001 tragedy. But not restricting their purview to such religious centers, the advocates also noted that certain big and well-known hospitals in metropolitan cities, offering specialized psychiatric services, were also functioning without a licence under the Mental Health Act.

Upon their suggestion, the Supreme Court directed Chief Secretaries of all States to conduct a survey of unregistered bodies that exist in the State, providing psychiatric care facilities. In case these bodies fulfil the norms they should be registered, if they do not, they should be closed down. The advocates report that different States have now filed affidavits before the Supreme Court. In many States some unregistered bodies have been closed down. In 14 States unregistered bodies admittedly are continuing to function. In some of these cases applications for licence are pending consideration but during such time, the institution is being allowed to function. In Kerala and Madhya Pradesh, faith healing centres have been stated to exist and they have not been closed down. The hon. Judge notes that it is but common knowledge that the number of unregistered bodies disclosed is but the tip of iceberg and the all pervading corruption within the system ensured that the unregistered bodies continue to function.

Coming to the *issue of framing of norms*, the hon. Judge notes that there are three sub-issues involved. The first is that Rule 22 of the State Mental Health Rules specifies only the norms for a 10 bedded psychiatric hospital or nursing home. It does not specify separate norms for halfway or quarterway homes, convalescence centres, rehabilitation centres, OPD facilities. It is important that separate norms be framed as per different categories of care required for different categories of patients. Secondly, the State Mental Health Rules are only a guideline. Each state can frame its own norms. 11 States and UTs have neither framed norms nor adopted the State Mental Health Rules of the others, most States, without application of mind, in their opinion, have chosen to blindly adopt the norms specified in Rule 22 of the State Mental Health Rules. Thus Himachal Pradesh having 3 private psychiatrists as per figures submitted by Union of India and Uttar Pradesh having 90-100 private psychiatrists have a common norm of 1 psychiatrist per 10 beds for psychiatric hospitals. Similarly the staff nurse to patient ratio of 1:3 and the attender to patient ratio of 1:5 is often very difficult, if not impossible to attain given the availability of trained manpower in psychiatry. The hon. Judge then discussed the third issue of availability of trained personnel. On the suggestion of the Amicus curiae, the Supreme Court had directed all the States to conduct a need assessment survey of infrastructure and personnel in the mental health sector. All States have now filed their affidavits and the reports are a revelation. In 11 States and UTs not a single psychiatric social worker exists either in the private or public sector while in 16 States and UTs there is no psychiatric nurse available. The number of psychiatrists is also very few and concentrated in large cities. The extensive hinterland generally does not have a single psychiatrist. There are only about 3500 psychiatrists, 1000 clinical psychiatrists, 1000 psychiatric social workers and 500-600 psychiatric nurses in the country. The Central Government has recommended that in the short term doctors from the general streams may be given short training courses from prestigious mental health institutions and detailed for the job. This is not seen as a viable, long term solution however.

The hon. Judge notes that a similar problem arises in respect of infrastructure. The Central Government admits that 1-2% of the population, i.e. 1-2 crore people suffer from major psychiatric disorders and 5% of the population, i.e. 5 crores, from minor psychiatric

disorder. It is also estimated that 25% of people who attend primary health care clinics suffer from various types of psychological problems. To cater to these people, there are only 37 specialized mental hospitals in the country in the Government Sector with a total bed strength of 18,000 beds and another 3500 beds in the 200 psychiatry units in Government Hospitals and medical colleges. In addition, according to Union of India, there are 40-50 private psychiatric facilities in the country. It has come out that in several States and UTs, there is not a single psychiatric hospital or nursing home.

To remedy this problem, the amicus curiae sought and obtained a direction from the SC to the Union of India and States to prepare plans for setting up of at least one Central Government run and one State Government run psychiatric hospital in each State. To this suggestion, apparently, the Central Government has come out with a reply that under the Mental Health Act it is not obliged to establish psychiatric hospitals. It has further stated that the trend now is towards community care instead of custodial care and so hospitals should not be set up. The amicus curiae have pointed out to the Supreme Court that the community care record of the Government is extremely suspect with District Mental Health program having been implemented in only 27 districts since 1982. There must be a minimum basic infrastructure in place. Further, psychiatric hospitals should not be construed only as custodial care units, but they should be developed into institutes of Mental health providing primary, secondary and tertiary care facilities along with convalescence, rehabilitation and training facilities for psychiatric personnel. Such an Institute in each State will have a synergistic effect and solve the problem of infrastructure as well as personnel.

The hon. Justice also pointed out that there is a persistent problem of mentally ill patients who have no one to look after them. The National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999 does not cover mental illness. It is important that mentally ill persons be also brought within the folds of this Act and the AC have given suggestion to the Supreme Court on this aspect. Union of India should also set up a Trust, which may accept a one-time donation for taking life long care of mentally ill persons after death of their immediate relatives. The private sector should also be associated with the scheme after framing suitable safeguards.

The next aspect the hon. Judge dealt with relates to the admission of involuntary patients. Under Section 19 of the Act, for admission of a mentally ill person who does not or is unable to express his willingness for admission as a voluntary patient, an application may be made by a relative or friend annexing two medical certificates from two medical practitioners, one of whom should be in Government service, to the effect that the condition of such mentally ill person is such that he should be kept under observation and treatment as an inpatient in a psychiatric hospital or psychiatric nursing home. A question is often raised that a general medical practitioner may not have the specialized knowledge to give such a certificate especially when such a certificate would rob a person of his liberty. However in the opinion of this hon. Judge, a psychiatrist has been deliberately not specified since there are too few psychiatrists in the country and often none available in semi-urban or rural areas. In any case, as the hon. Judge sees it, the further requirement is that the medical officer incharge of the psychiatric hospital or psychiatric nursing home should also be satisfied and such a person is often a psychiatrist. A further question is often raised that in emergency cases it may not be possible to obtain certificates from two medical practitioners. The answer to that is provided by the proviso to Section 19(2) which specifically states that instead of requiring such certificates, the medical officer incharge may cause a mentally ill person to be examined by two medical practitioners working in the hospital or nursing home.

While Section 19 provides the most convenient way for admission of involuntary patients, there are certain other procedures prescribed under Section 20 to 29 of the Act, as noted by the hon. Judge. Section 20 in particular relates to reception order which may be passed by the Magistrate. The other sections also relate to orders that may be passed by Magistrates in respect of mentally ill-persons found wandering at large or dangerous by reasons of mental illness or treated cruelly or neglected etc. A question has been raised about the phrase “temporary treatment order” mentioned in Section 20 of

the Act. This phrase however, as pointed out by the Judge, has not been defined in the Act nor has it been used else where. From a reading of the Act the only explanation possible is it refers to admission under Section 19 of the Act.

A question that has often been raised, no doubt by psychiatrists, is whether a psychiatrist can be booked for either treating an involuntary patient or taking him to the hospital for admission. In this respect, the Judge notes that infact Section 92 of the Act comes into play and is favourable to the psychiatrists. Section 92 specifically states that no suit, prosecution or other legal proceeding shall lie against any person for any thing which is in good faith done or intended to be done in pursuance of this Act or any Rules, Regulations or Orders made thereunder.

Inspection of the psychiatric hospitals and psychiatric nursing homes is another aspect that was referred to, by the hon. Judge. The State Government or Central Government is entitled to appoint visitors for inspection of every psychiatric hospital and nursing home and not less than three visitors are required to make a joint inspection once in every month of every part of the psychiatric hospital or nursing home in respect of which they have been appointed. The judge notes that this provision is however more complied with in its breach. In the affidavits filed before the Supreme Court, it came out that in several States either visitors had not been appointed or they had not inspected any psychiatric hospital or nursing home for more two to three years.

The Supreme Court has in its order dated 12.4.2002 laid down that the Board of visitors should also include the Additional District Judge and/or Chief Judicial Magistrate and/or the President of the Bar Association of the area in addition to the State Disability Commissioner or his nominee. The Supreme Court has also laid down that a monthly record of visits of the Board of visitors and a quarterly report should be filed with the State Mental Health Authority. The steps have been initiated by the Supreme Court only because the existing arrangement prescribed under the Act has not been implemented. The amicus curiae have suggested to the Supreme Court that since the number of mental health institutions to be inspected may be large in a particular State, separate teams of visitors should be assigned to separate mental health institutions. It has often been complained that since inspection can be conducted at any time and the records even of voluntary patients can be checked, great difficulty is often caused and the privacy of voluntary patients may also be compromised. In the personal opinion of this judge, the provision has been made in the interests of the patients and if properly implemented, is also necessary for welfare of the patients. However having regard to the extent of corruption in the country, as the judge notes, this provision can also be misused by unscrupulous elements to harass persons running psychiatric hospitals or nursing homes.

The last issue that the Judge dealt with relates to Human Rights and Legal Aid. Although Section 81 of the Act specifically states that mentally ill persons are to be treated without violation of human rights, the AC have come across several instances of chaining of mentally ill persons. This was the case in Erwadi also. On the amicus curiae's suggestion, the Supreme Court directed the Union of India and the States to ensure that no mentally ill person was chained in any part of the State and also to spread the message through print and visual media that chaining of mentally ill persons was an punishable offence. In the affidavits filed by the States also the Chief Secretaries of three States have reported incidences of chaining in their States, which were dealt with by the authorities.

The Supreme Court in its order dated 12.4.2002 also stated that patients and their guardians shall be explained their rights by a team of two members of the legal aid and a judicial officer, under the Mental Health Act, in a language known to them, at the time of admission to any institute. They should also be informed whom to approach in case their rights are being infringed. A practical problem that arose is that since admissions take place 24 hours a day, it may not be possible to comply with the order literally. The amicus curiae have therefore suggested to the Supreme Court that it may be sufficient compliance to display the rights of the patients in bold letters in English and the Regional language in every psychiatric hospital or nursing home and further there can be frequent visits by the members of the legal aid and judicial officer to these institutions to speak to the patients directly about their rights.

✧ ✧ ✧

Isle of alienation

(a *shubharthi's* poignant experience)

They coaxed,
and I cajoled myself
to the birthday celebration;
or,
that is what they said it was.

Despite the gleeful cacophony
I began sinking within myself,
evading staring waves of unsmiling faces.

Soon balloons burst, lights flashed,
clapping and singing trailed,
seemingly
for hours without end.

Whatever happened to the chips,
cake, cola and the colourful caps?
Was I self-absorbed when passed around?

When silence numbed me at last,
unwelcome stigma had defiantly left,
and just around me,
neat rows of unused chairs!

Gurudatt Kundapurkar
Facilitator, SAA-Ekalavya SHS Group, Pune
Nov 27, 2002

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.