

## Editorial

Children in Indian schools are now increasingly being brought into the trap of the drug companies by being labeled with a mental illness: attention deficit disorder, behaviour and conduct problems, depression, academic backwardness.... We are hearing about this everywhere, even as the WHO celebrated the last year's MH week with the theme of childhood mental disorders!

Many schools in India now have a counsellor and a referral system to medical professionals to deal with academically backward children. This trend of drugging children is worrying, as international policy makers are cautioning loudly against prescribing antidepressants, especially SSRIs, for children, due to the heightened risk of suicide and violence.

In all this, we are not talking about how children's lives have changed over the years- the pressures of the present education system, the neglect of children's health, the depletion of essential nutrients from our foods, allergies brought on by environmental pollution, replacement of diverse and complex grains and pulses with homogeneous and instant foods, and the fact that wheat, fruit and vegetable has been replaced by magi, pizza, chips, chocolates and Pepsi. Parents around the world are protesting the takeover of their children's lives by the schools, the psychiatrists and the pharmaceutical companies.

Against this background, we also need to consider the therapeutic needs of custodialised, traumatized and victimized children. Their legal and mental health needs are not met within the juvenile justice system.

The state of Maharashtra has been irresponsible about dealing with complaints from families with a psychosocially disabled person. In a recent case in the Mumbai High Court, the Bench headed by Chief Justice AP Shah, admonished the Maharashtra Disability Commission on its poor reading of the law (Section 47).

This issue of *aaina* reports on a recent initiative to draw up a Charter of Rights for persons with a psychosocial disability. Further, news about a study group on the UN Convention on Disabilities is also reported. The 7<sup>th</sup> Ad Hoc Committee Meeting begins on the 15<sup>th</sup> of January and goes on for three weeks. The Chairperson's Draft, which is an assimilation of the discussions in the proceedings so far, will be discussed.

The story of a man diagnosed with bipolar illness, and who bravely used himself as an experimental laboratory, is also described. We are also happy to report news of a recent verdict in the US, where the court granted \$1.6Mn to a woman who suffered from tardive dyskinesia, as compensation.

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Aaina is a mental health advocacy newsletter.

Aaina is an opinion-making and opinion-leading newsletter, with a consistent message of user empowerment, good practice, policy, legal and social reform in the mental health care sector in India.

Aaina covers issues in community mental health, the role of NGOs in mental health, self-help and healing, the use of non-medical alternatives in mental health, human rights issues in mental health, institutional reform, ethical dilemmas, policy discussions, and the mental health needs of special groups (young people, women, the poor, sexual minorities, persons with a disability, etc.).

Aaina covers themes related to disability caused by psychiatric drug use, and long term institutionalization. It has a great interest in how much money pharma companies are making by pushing hazardous drugs onto poorly informed communities.

Aaina provides a forum for users to express their problems and dialogues with the mental health service system, and their demands for change. It also addresses issues of social living for persons with a psychiatric disability, stigma, discrimination and deprivation of the right to life and liberty, especially of the poor and the homeless.

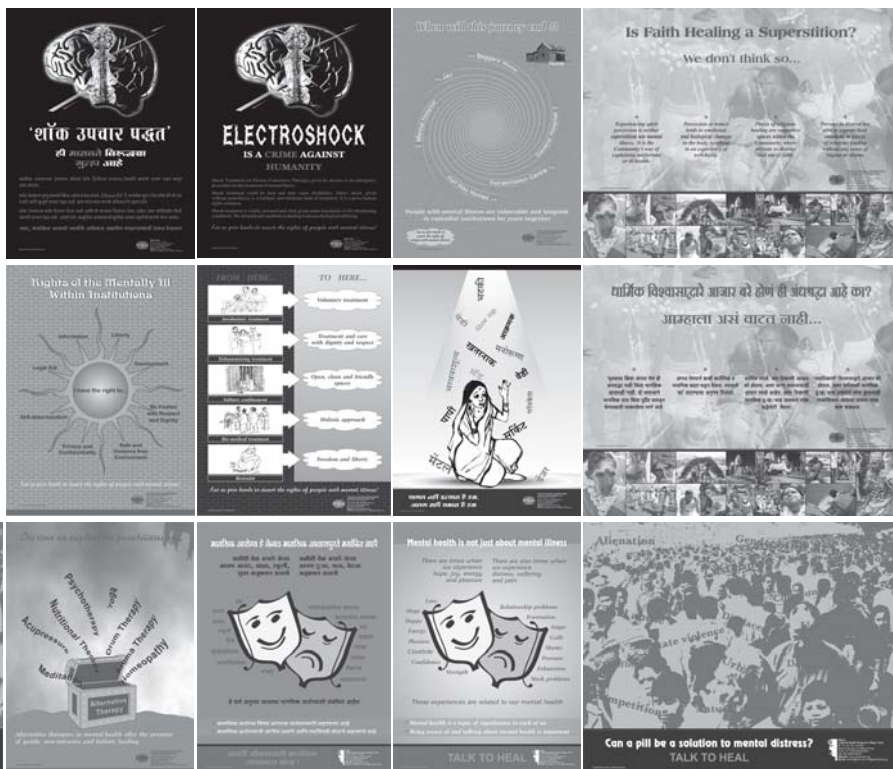
If you wish to make a donation to aaina, please make a DD or a cheque in favour of "Bapu Trust for Research on Mind & Discourse, Pune" and post it to our mailing address.

**New Resources in Mental Health**

1. "Healing from Violence... a Counsellor's Manual", produced by Center for Advocacy in Mental Health / Majlis, 2005.

2. "Rights of persons with mental illness" - a set of colourful and hard hitting posters on the key rights issues affecting the lives of persons with a mental illness.

Visit our website, [www.camhindia.org](http://www.camhindia.org) for further details.



## Mental Health aspects of Victims of Crime

Parul Sharma

Every woman, man, youth and child has the human right to the highest attainable standard of physical and mental health, without discrimination of any kind. This is enshrined in our Indian Constitution and the Universal Declaration on Human Rights. Enjoyment of the human right to health is vital to all aspects of a person's life and well-being, and is crucial to the realization of many other fundamental human rights and freedoms. Furthermore, the social right of victims of crime and their sensitive needs for mental health support is based on the Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power, 1985. (Resolution adopted by the UN General Assembly, non-binding principles upon member nations.) Yet everyday, disparity in health care takes place in our country. People, needy, less fortunate or those born outside the system with mental health disorders are tied to their ward beds in the name of health care. Violation of their rights to dignity and respect are not uncommon.

The World Health Organisation (WHO) reports that 450 million people worldwide are affected by mental, neurological or behavioural problems at any time. Furthermore, according to the WHO, most middle and low-income countries devote less than 1% of their health expenditure to mental health. Consequently, mental health policies, legislation, community care facilities, and treatments for people with mental illness are not given the priority they deserve. Barriers to effective treatment of mental illness include lack of recognition of the seriousness of mental illness and lack of understanding about the benefits of services. Policy makers, insurance

companies, health and labour policies, and the public at large – all discriminate between physical and mental problems.

### The Indian institutional mental care experience

The Indian experience on institutionalised mental help as well as institutionalisation of patients itself has not been civilising. A report prepared for the National Human Rights Commission (NHRC) in 1999 after an empirical study of mental hospitals in the country made a condemnation of the state of mental health institutions. "The findings reveal that there are predominantly two types of hospitals," the report said. "The first type do not deserve to be called 'hospitals' or mental health centres. They are 'dumping grounds' for families to abandon their mentally ill member, for either economic reasons or a lack of understanding and awareness of mental illness. The living conditions in many of these settings are deplorable and violate an individual's right to be treated humanely and live a life of dignity. Despite all advances in treatment, the mentally ill in these hospitals are forced to live a life of incarceration."

"The second type of 'hospitals'," the NHRC report continues, "are those that provide basic living amenities. Their role is predominantly custodial and they provide adequate food and shelter. Medical treatment is used to keep patients manageable and very little effort is made to preserve or enhance their daily living skills. These hospitals are violating the rights of the mentally ill persons to appropriate treatment and rehabilitation and a right to community and family life".

The NHRC released its report 6 years

ago, but the conditions of persons with mental illness in institutions remain an urgent cause for human rights concern. In Gwalior Mental hospital, for instance, it was found that persons with mental illness were left in nakedness; the explanation was that they tore their clothes if they were given them.

Similarly, at Erwadi in Tamil Nadu, patients who were chained to each other at a home for the mentally ill caught fire and killed 28 people in 2001. The press raised the issue. Chaining of mentally ill patients was also a practice, and has since then been outlawed by the reforms introduced by the Supreme Court of India that ensure that the fundamental rights of institutionalised patients are not violated. The ruling also set the climate for increased sensitivity on mental health support through actual mental health professionals.

### Mental health care for victims of crime

Research and professional experience shows that secondary victimisation, generated either by institutions or individuals, is often experienced by victims in the aftermath of crime and leaves them in need of help. Secondary victimisation involves a lack of understanding of the suffering of victims which can leave them feeling both isolated and insecure, losing faith in the help available from their communities and the professional agencies. The experience of secondary victimisation intensifies the immediate consequences of crime by prolonging or aggravating the victim's trauma; attitudes, behaviour, acts or omissions can leave victims feeling alienated from society as a whole.



Secondary victimisation in itself is not an unusual phenomenon in our society. It most recently appeared in an Indian courtroom on the 3 May 2005, when a convicted rapist proposed marriage to his victim. The man was convicted of raping and seriously injuring the 22-year-old nurse in September 2003 at the hospital where they both worked. Minutes before sentencing was due on Tuesday 3 May, he issued his marriage proposal. Postponing the sentence until the next day, the Judge asked the victim whether she would accept the proposal from her attacker, who had hoped it might lower his sentence. The victim told the court she had rejected the offer.

Did the court as a carrier of justice at all consider the dangers to women caused by such a precedent? If the convicted rapist said he was offering to marry the woman because the stigma of rape in India meant no one else would, do both judiciary and the law also have the same thinking pattern? What social responsibility was the court fulfilling?

### **Indian case law is missing mental health and rehabilitation aspects**

Remarkable developments have taken place both internationally and nationally when it comes to prioritising child rights, but the links between child abuse, child labour and the care for a child's mental health are still absent. In India there is no separate law with regards to sexual assault of children. The general law on rape contained in the Indian Penal Code covers child sexual abuse and assault. Similarly, the Juvenile Justice Act 1986 has an impressive preamble, but despite this, the Act scarcely touches upon the subject of child sexual abuse, and completely leaves aside therapy and mental health considerations.

The Proposed Commission for the Protection of Child Rights Bill, 2005 proposes to be the legal mechanism to oversee and review the

implementation of the National Policy for Children. It will also help improve the survival rate, health, nutrition and education of children, particularly girls, and equip them to become economically productive adults.

Chapter ii of the proposed Bill abruptly demonstrates the generalisation of the special needs of the individual child. By mixing special needs of children, for instance child health and child welfare as interchangeable areas, or child psychology and sociology as filling the same functions in all situations for all children, the legislators and policymakers have indicated the inability to understand the importance of specialised representation in the form of experts.

Chapter v of the Bill, through section 25 and 26 regulates the constitution and functions of children's courts. Section 25 states that for the purpose of providing speedy trial of offences against children or of violation of child rights, the state government may, with the concurrence of the chief justice of high court, by notification, specify at least a court in the state or specify, for each district, a court of session, to be a children's court. Furthermore, section 26 states that for every children's court a special public prosecutor should be appointed, or an advocate who has been in practice not less than seven years.

In Vishal Jeet vs Union of India (air 1990 sc 1412), the Supreme Court directed steps against child prostitution. One directive was to establish advisory committees with experts from all fields to suggest measures for eradicating child prostitution, care and rehabilitation of rescued girls and setting up of rehabilitation homes. The judgement did indicate a good understanding of the sensitive situation of children coming out of prostitution. But, again the judiciary failed to understand

the importance of defining 'rehabilitation'. Experts may argue that defining such terminology is not within the court's mandate. But, when directions concerning child rights are formulated it must be understood, by law, that either the inclusion of expert opinions is put in or judges are sensitised towards issues such as child psychology.

The mandate of the planned children's court is a repeat of the vague mandate expressed in the Protection of Human Rights Act, 1993, where Human Rights Law could be "anything under the sky". Again, a general sessions court will act as a guarantor for the implementation of rights, whether it is human rights or child rights.

A crucial question to ask here is, whether the drafters of the Child Rights Bill 2005 related the particular needs of a child to their own children?

The role of mental health of rescued and victimised children is also absent in Indian case law. *M C Mehta vs State of Tamil Nadu* (AIR 1991 SC 417), is undoubtedly the most significant case on improving condition of children rescued from hazardous labour. Here it was argued that children below 14 years cannot be employed in any factory, mine or other hazardous work and they must be given education. The Supreme Court ruled that employers of children were made liable to pay Rs 20,000 in compensation for every child employed. The government was asked to provide job to an adult member of the family in lieu of the child or deposit Rs 5000 for each child. Thus there would be a corpus of Rs 25,000 for each child. The fund would be deposited in the "Child Labour Rehabilitation-cum-Welfare Fund". The payment made from the fund or the employment given would cease if the child is not sent to a school. The *M C Mehta* case is most relevant for the understanding of a child's right to education after rescue

from hazardous employment. There is however, one aspect missing in this case between the rescuing from child labour to the right to education. The long hours of work and monotony, the constant abuse and oppression for children in employment require the child's thorough mental health rehabilitation as a step prior to education. This was completely left out in the M C Mehta judgement.

In cases of legislations concerning children and their rights, mental health considerations must become an inextricable component of law, and therapists must be included in the legal framework both as an appreciation of evidence and for the future benefit of the child- as a long term remedy. Such an inclusion and institutionalisation would distant the risks attached to the common blunders committed by lawyers dealing with child victims in trauma. For instance, the daily scene in an Indian courtroom, where lawyers repeatedly would ask a child to narrate violent instances such as sexual assault, not realising the damaging effect such a legal methodology would have on a child.

In India, the most decisive evidence in child sexual abuse cases is the medical report, which has the core aim to trace the offence. The duty of the medical professional is to examine the child victim and gather information that will protect and/or validate the traumatised child. In the cases of refusal to undergo a medical examination the child is referred to a therapist, but only for issues that is making the child uncooperative.

In the cases of assaults against women, statistics from year 2000 show that a woman is raped every hour in India. Still victims are often reluctant to report rape. In the court, they are supposed to prove that the rapist sexually penetrated them in order to get a conviction. This can be damaging, mainly so when

defence counsel uses harsh and callous rhetorics to further victimize the survivor. Eminent judges and landmark cases talk of rape not merely being a physical assault but is often destructive of the whole personality of the victim. "...a rapist degrades the very soul of the helpless female". Furthermore, it has also been realized that courts should shoulder a great responsibility while trying an accused on charges of rape. It has been felt that such cases must be dealt with "utmost sensitivity". Unfortunately and following old patterns, the court has not defined what should be understood by great responsibility or sensitivity.

Furthermore, in *Majlis Manch vs. State of Maharashtra & Ors.* a 9 year old deaf and mute girl institutionalized in an observation home, was raped and the medical examination indicated, "Skin injury mark. Bite mark on right cheek and multiple abrasion marks over skin, buttocks and both legs". Even in such a dreadful case, where the child is not able to express pain or explain even minimally what has happened to her, even in such cases there has been no realization or will to make mental health considerations must become an inextricable component of law.

### **Civil Society Measures a risky alternative**

Civil society groups and NGOs have recognized the lack of insight and priority amongst policy makers and legislators to mental health concerns. They have taken up the battle, generally though, in an unguided manner. Help-lines, friendly and non-professional counselling is given to patients in need of professional mental health support. This can amount to dreadful outcomes, when for instance a victim of domestic violence come to seek what in her view is guidance within the framework of counselling, but instead receives a cultural orientation on how the role of the

Indian woman is to compromise and how with time the violence against the victim may reduce.

For example in Punjab, one slap a day for a woman is almost a matter of culture in some parts. So where and how do we start sensitising people of violence against women being a crime - in all forms, mental, physical and emotional? The International Centre for Research on Women (ICRW) suggests that 80 per cent men from Punjab think violence is justified if a wife is "disrespectful" and 60 per cent justify it if a wife "does not follow instructions". Such social customs and attitudes, which still consider women inferior, abet domestic violence. Scenarios where a woman comes to seek help in and receives counselling where she is brutally informed that "everything will be fine in due time" and that she must not leave her husband or abuser can result in very violent affairs.

The NHRC has emphasised the need of opening more than one women police thanas (stations) in a district of different states to deal with crime against women, but what is being done about the "cultural beliefs" in our legal system? In the meantime, every six hours, a young, married woman is burnt alive, beaten to death or forced to commit suicide, and one in five continues to face domestic violence from the age of 15. This, when violence against women has been already been recognised as a human rights violation. Victims of violence, physical, sexual and even psychological, many women are today a statistic in the National Family Health Survey.

In several interactions I have had in Amritsar and Chandigarh with women's rights organisations and their helplines, I have learnt that individuals with no training in mental health counselling give advice in a majority of cases. There is currently no set protocol or system in place. This only makes it very difficult to assess whether the counselling

offered meets victims' needs. Protocols and mandates have to be brought about on the basis of which a counsellor can be judged. Failing the standards set should automatically lead to trial of the counsellor. Similarly, many private initiatives where homeless victims and socially deprived are kept in homes and shelters, and are run based on the concept of 'humanity' and 'sewa'. Staff at these shelters may have no training whatsoever to attend to the special needs of victims or patients with psychological disorders. Still, it is difficult to criticise these groups, which have stepped out to provide what our constitutional welfare state is overlooking. Not to forget the immense public awareness these groups are creating.

Civil society volunteerism can be an excuse for the state to withdraw from its role as a provider of health care. The state instead has to be made to fund group counsellors who help the women and children in their homes and shelters. The state cannot abdicate the entire responsibility to the non-governmental organisations; it has to play its role of welfare state. Also, the wrongful socio-cultural perception of the 'doctors of the mad', '*pagalo ke doctor*', has to diminish, if our society is inclined to do justice to people in need of mental health care.

### **An expertise oriented approach needed**

When society does not demonstrate responsibility to victims, pain and suffering is prolonged. In the longer term, the victimisation brings about adverse consequences on all aspects of the victim's life. Unsupported victims may, in the hope of protecting themselves, take refuge in self-defence or retaliation. Victims of crime, their families and those close to them ask, above all, for recognition of their suffering. This recognition should not be limited to intervention in the criminal justice

process. Victims, as well as offenders, should be entitled to benefit from effective programmes of social reintegration.

Democratic societies have an obligation to alleviate the effects of crime, including the adverse consequences that victimisation has on all aspects of life. Victims must be supported in a way, which shows an understanding of the whole range of their problems. All victims of crime have the right to ask for their privacy, their physical safety and their psychological well-being to be protected. Child victims in particular may experience difficulties obtaining support, either from their family or from professionals. Specialist services should be made directly accessible to them, and professionals made available to provide individual support for each child.

Ultimately, private initiatives as well governmental operations need inputs from professionals in the field of mental health, from psychologists and psychiatrists. Efforts to provide accurate support and right to mental health care cannot solely be left to any one group alone, whether civil society or governmental. A collaboration between the two, and a more expertise oriented approach towards mental health has to be realised. This becomes a must in a society such as ours where stigma and discrimination remain barriers mental health expertise reaching those suffering from mental disorders.

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## Mind Over Matter

What really is thin?  
 What is really fat?  
 Is he always the dog?  
 She in all ways a cat?  
 If they're in power  
 Why do they shake?  
 Does feeling pain  
 Cause one to break?  
 Do we have an anthem  
 Or just another poem?  
 When you escape a house  
 Did you run from home?  
 When we're up so high  
 Don't we look down?  
 If you try to remember  
 Are you apt to frown?  
 Paint too many rainbows  
 And it all turns black  
 So you fall to pieces  
 Yet you look intact  
 Oh why bother  
 Attempting to find  
 The thing that's lost  
 Is just your mind.

Ciera S. Louise c.  
 March 24, 2005

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## Access to Justice for persons with mental illness

### A Charter of Rights

In the Indian context, the topic of Human Rights needs to be understood as one of the tensions between the State and its individual citizens. The State has the constitutional mandate of being the guarantor of rights, but in practice, we often find that the State is the violator of certain basic rights that every individual has as a human being. The prevailing socio-cultural climate is overwhelmingly patriarchal. This results in serious violations of women's rights although the Indian Constitution guarantees equal rights to both men and women. In the case of women, we find widespread violations, as for example, in the case of involuntary commitment, deprivation of property rights by alleging mental illness, restriction on mobility and increased vulnerability to sexual abuse. The risk of violations increases proportionately with increased vulnerability and marginalization. Persons with mental illness form one of the most marginalized and vulnerable population segments in India, as civil society has little understanding of mental illness and that allows the State to remain callous and non-committed towards such people. It is this scenario that makes it crucial to launch a strong advocacy initiative towards protecting the rights of persons with mental illness.

While a number of national and international instruments exist, these instruments have their limitations:

- The 1991 Principles for the Protection of Rights of Persons with Mental Illness has been criticized for liberally allowing forced treatment and involuntary commitment
- The Draft UN convention on the Rights of Persons with Disabilities,

currently in discussion is aiming at changing some of these contentious issues in the 1991 document

- Mental health remains one of the most neglected areas in India since it has not yet caught the imagination of civil society
- The accent remains on involuntary commitment in admission and discharge
- A majority of State mental hospitals function primarily as drug disbursement centers, with little or no arrangements for therapeutic support in the form of psychosocial rehabilitation
- Transfer procedures between custodial institutions continue to be highly dismissive of the personhood and the dignity of persons being transferred

Globally today, there is a movement towards creating a more inclusive society. Applied to persons with mental illness, inclusion would imply:

- Promoting equal opportunities for citizens with mental illness, for a person with mental illness does not lose her / his citizenship
- Persons with mental illness should have decision making rights in their own treatment and care
- The mental health service delivery system must be based upon values of dignity, respect, autonomy and self-reliance, rather than on management needs
- Healing opportunities for recovery and living an independent life must be included within the treatment and care package
- There must be mechanisms for guaranteeing other rights as citizens

It is with these principles in mind that a national level consultative meet involving sectoral experts in mental health and various forms of disabilities from across the country was organized.

Ratnaboli Ray and Bhargavi Davar, both Ashoka Fellows, organized the event with support from the LFAI (Law for all initiative of Ashoka) on 22<sup>nd</sup> and 23<sup>rd</sup> August 2005, at the IIM campus, Kolkata. This gathering brought together important players from the field of mental health with varied perspectives and experiences. A Charter of Rights for persons with mental illness was proposed at this meeting. This will form the basis of a second national level consultative meet and other regional meets to finalise the Charter of Rights.

You may also find the Charter of Rights at the website: [www.camhindia.org](http://www.camhindia.org) for comment and feedback.

Three areas were explored: Parameters of care; Rights within family & community; Grievance redressal mechanisms. The common minimum rights agreed upon in the consultation were as follows:

#### A) Parameters of Care

##### A1. Right to Quality care, including:

- ◆ Right to least restrictive and least intrusive treatment, including prohibition of isolation
- ◆ Individualised plan for care, periodically reviewed and recorded
- ◆ Preserving and enhancing individual autonomy
- ◆ Access to multidisciplinary teams and non-medical care
- ◆ Right to live, work and receive



treatment within the community without any form of discrimination on the basis of religion, caste, age, language, sexual orientation and gender

**A2.** Right to protection from cruelty and torture, with torture being defined as physical torture and unauthorized experimentation.

**A3.** Right to basic needs like food, space, clothes, personal hygiene

**A4.** Right to confidentiality

**A5.** Right to voluntary treatment, with involuntary commitment restricted to standard protocols for assessing dangerousness of self and others, lack of competence not based simply on diagnostic category, and with right of appeal for review with legal aid available on site

**A6.** Right to information on care and treatment

**A7.** Right to social security, including insurance and adequate standard of living, with special provisions for mentally ill persons with multiple disadvantages (e.g. women/children/poor / homeless / facing calamities and conflict / physical disability)

**A8.** Right to free medical and non-medical care at primary health centers and district mental health programme levels, as well as on site and within the community.

### **B) Rights within family and community**

**B1.** Right to information and education for person with mental illness and family on nature and level of illness, as well as treatment and care needs

**B2.** Right to accessibility to / availability of various modes of treatment, help and rehabilitation

**B3.** Right to work and gainful employment under conditions of equal opportunity and equal remuneration not less than the nationally determined minimum

wage and entitlements under the Indian constitution

**B4.** Right to privacy of home, family, correspondence, intimate relationships, sexual relationships, including alternative sexualities, marriage, giving birth and parenting, living with children, and protection of law against all discriminatory practices

**B5.** Right to owning property, with provisions for necessary assistance, depending on the disability determined through standard protocols, and protection of law against all discriminatory practices

**B6.** Right to voluntary contraception, including tubectomy, hysterectomy, medical termination of pregnancy for women, vasectomy and sterilization for men

**B7.** Right to vote and hold public office.

### **C) Right to grievance redressal mechanisms**

**C1.** Right to information about all redress mechanisms, including those relevant to institutions, land and property, marriage, divorce, guardianship, adoption, custody, contracts, work and employment

**C2.** Right of access to redress mechanisms, including legal aid and representation, with special focus on women and children in institutions, in case of inhuman / harmful treatment, and with special provisions for legal safeguards for disability.

**C3.** Right to mobilize, form and be a part of associations towards effective grievance redressal

**C4.** Right to protection and legal redress against custodial and criminal offences committed against persons with mental illness including offences committed in the community

**C5.** Right to legal redress against indiscriminate transfer between custodial institutions, with special

focus on homeless persons with mental illness in institutions

**C6.** Right to legal recourse against being used as research subjects without informed consent.

### **The Way Forward**

This Charter of Rights has been drafted as the first step towards a consolidated advocacy and campaign initiative throughout the country for ensuring the rights of persons with mental illness. The goal is to create a National Alliance of multiple stakeholders to proactively implement nationwide advocacy and campaign programmes for the rights of one of the most marginalized and vulnerable population segments in the country.



### **Drug Tracks**

*In October, 2005, a USA jury (Sylvia Jones v. Jeffrey Alan Margolis in Tappahannock, Virginia) delivered a major victory to a woman harmed by a psychiatric drug-induced condition known as Tardive Dyskinesia (TD). It is well known that nearly 100% of patients on anti-psychotic medication for over two years are likely to suffer from TD, a kind of brain damage that can involve persistent and often permanent disfiguring involuntary muscle movements. Sylvia Jones, at 21, was put on Triavil, a combination drug, comprising of perphenazine and amitriptyline, in 1982, when she had anxiety. She was maintained on the drug until 1997, and with an increased dosage until 2003, despite Sylvia not experiencing any psychotic symptoms at any time. In 2003, Sylvia developed severe, painful and crippling spasm of the neck, diagnosed as TD. Since 1997, Sylvia had been completely disabled, and isolated, by a variety of motor abnormalities associated with TD. Dr. Peter Breggin, a psychiatrist who turned anti-, and who has been working hard to bring such cases before the court and the public, initially evaluated the case. In October 2005, Sylvia was granted a \$1.6M compensation. ■■*



## Healing oneself from bipolar illness

>>Allen Darman, shared in [integrative psychiatry@yahoo.com](mailto:integrative_psychiatry@yahoo.com)

Very early on in my recovery from bipolar, before I ever became aware of the nutrient chemistry and malabsorptive issues that were inherent in this condition, my recovery from my illness focused on learning basic coping skills in order to avoid the worst of symptoms.

One basic coping skill that I learned was that it was important to be able to recognize my early warning signs, and then make adjustments accordingly.

In studying mania in myself in 1995, I learned that when I was becoming manic, I had a very strong tendency to “feed the mania”, and make it much worse. When becoming manic, I would drink more coffee/eat more sugar (which are stimulants), I would eat less (as eating slowed me down), I would seek out more tasks to do (become busier and busier, making lists of what to do), I would seek out more stimulating environments (I’d often drive 400 miles to go play poker all night long in a casino), and I would see no need for sleep.

In studying depression in myself in 1995, I learned that when I was becoming depressed, I had a very strong tendency to “feed the depression”, and make it much worse. When becoming depressed, I would isolate from other people much more, I would watch a lot more TV, I would be far less active and do a lot less, and I would eat a lot more junk food, drink more soda pop, etc.

Once I had a basic understanding of the above tendencies to “feed into” whatever mood state I was in at the time, as well as a basic understanding of manic depression, I found it wise to simply “do the opposite of my natural tendencies”, as much as I possibly could.

When becoming manic, I learned to avoid sugar and coffee, I learned the need to eat regularly despite a serious lack of appetite, I learned to quit making lists and starting more projects, I learned to avoid staying up all night in a casino playing poker, and I learned of the great need to control my sleep by taking over-the-counter or prescription sleep medication. (As a result of this knowledge, I ended up taking 2 mg. of Klonopin daily for 18 months straight beginning in April 1996, often mixing this Klonopin with both alcohol and pot for greater effect. I was that bad.)

When becoming depressed, I learned that it was better to force myself to continue to see people rather than isolate myself in the cellar at home, I learned it was better to not watch TV all night and day, I learned it was better to force myself to get up and do whatever I could instead of just click from channel to channel, I learned it was better to get in the shower daily than not to, I learned it was better to avoid junk food and eat as healthy as possible, and I learned it was better every single morning that I was depressed to look myself in the mirror and tell myself “I forgive myself for any and all depressive behavior and lack of functioning that I have at this time, and God forgives me for this as well” and “I am not a bad person, I am simply a person that is temporarily depressed.”

Saying these things greatly helped me to avoid the downward spiral of lowering self esteem when I was depressed. This downward spiral of self esteem had a really strong tendency to suck me into a much deeper state of depression. I was “my own worst enemy in depression”. I had been such for almost 30 years, prior to learning to stand in front of the mirror and state

the above, as well as learning to do the opposite of my natural tendencies when I was becoming depressed. In 1995, simply as a result of a little bit of knowledge, my being “my own worst enemy in depression” stopped almost immediately. This situation continues to this day.

The understanding of learning “to do the opposite of my natural tendencies” when I was becoming manic or depressed, and the understanding of how to avoid becoming “my own worst enemy in depression” really helped me a great deal in the beginning of my recovery from manic depression during the mid 90’s. It did not take a whole lot of discipline to do this, as I had suffered from some really severe symptoms on both the high and low end of bipolar disorder for years... and I sure did not want to suffer any more. I did not need discipline to be motivated here. I was simply avoiding inevitable pain as a result of severe mania or depression by using a little bit of knowledge. No one likes pain.

However, the above basic coping strategy is nothing like I know now about my illness.

As a result of my

(1) devoting my whole heart and soul to the goals of (a) overcoming and (b) understanding manic depression since my initial diagnosis in June 1994,

(2) taking over 80,000 capsules of individual and blended amino acids since 1997,

(3) taking perhaps another 50,000 capsules or tablets of various vitamins, minerals, essential fatty acids, probiotics, digestive enzymes, HCL, etc,

- (4) reading a few hundred books,
- (5) discussing my illness with hundreds, if not thousands, of people,
- (6) spending perhaps close to \$200,000 to understand manic depression since my initial diagnosis in 1994,
- (7) my hundreds of trials in regard to intentionally inducing and then correcting manic and depressive symptoms, some of which were rather severe, as “a self appointed guinea pig for the whole world”, and
- (8) a life history, work history, and test scores that are strongly indicative of at least “near genius” intelligence, if not genius... I cannot help but feel that what I am representing in this egroup and elsewhere with my written material represents some of the most advanced understanding of manic depression in existence.

No, I do know it all there is about my illness, but I sure think that I know a great deal. I knowing what I do, I can not see how the proper treatment of manic depression (the “cure”) should not involve

- (1) the use of a wide range of essential nutrients,
- (2) the use of a wide range of gut healing and/or gut corrective measures, and
- (3) an effective resolution of the extremely common bipolar issue of the presence of multiple hidden food allergies.

I see the doctors of the future in regard to bipolar disorder (and many other mental illnesses) as simply being “educators” and “empowerers”, and not the doctors that they are now. Our wellness is up to us. Only “we” (the person affected) can “cure” ourselves of our own “mental illness”. A doctor of the future’s greatest true value to us is to simply

steer us accurately in the right directions that are necessary for this to occur (the “cure” of ourself).

Ideally, the process of doctors assisting bipolar persons to recover should involve these doctors doing all that they can to empowering bipolar persons to take full personal responsibility for their own illness, and full personal responsibility for their own recovery.

Without this foundation step, no true recovery from manic depression is even possible, in my opinion.

And ideally, the process of doctors assisting bipolar persons should involve

- (1) teaching bipolar persons basic coping skills,
- (2) teaching bipolar persons how to apply nutrient chemistry safely and effectively to themselves,
- (3) teaching bipolar persons how to identify food allergens in themselves via an elimination diet,
- (4) teaching bipolar persons how to resolve candida and/or other intestinal dysbiosis issues in themselves,
- (5) teaching bipolar persons how to correct for any and all common problematic malabsorptive issues in themselves, as bipolar disorder is simply “a complex sub-clinical malabsorptive syndrome in disguise”,

(6) steering us to the best books and websites on all of the above,

(7) reviewing the treatment of ourselves from time to time, with the idea of pointing out something that we may be missing and monitoring our progress until this review process of our self treatment is no longer necessary as we can “carry the ball” ourselves,

(8) helping us with valid and accurate advice when “we get stuck” in regard to our self treatment of this illness, and

(9) prescribing medicines (drugs) to us for short term chemical control until the above measures take hold such that they give us far greater chemical control over our symptomology than any medication could ever do.

I am fully aware that the above “ideal treatment” of bipolar disorder (and other mental illnesses) is not going to be a very popular option with either orthodox or alternative health practitioners, for it takes a great deal of the power, control, and money out of any medical practice whatsoever, alternative or otherwise. Such an approach puts health back in the patient’s hands... where it belongs.

*Allen Darman (www.mental-health-matters.com) Also refer to his article on nutritional treatments for bipolar illness at:*

*www.alternativementalhealth.com/articles/default.htm*



## A jolt for the Maharashtra Disability Commission

The Maharashtra Disability Commission is well known among the mental health circles for its studied neglect of the needs of persons with psychosocial disabilities. The department officials are often not even aware of the fact that "disability due to chronic mental illness" is included in the list of disabilities. Getting a disability certificate is a major issue. Complaints redressal procedures can take anywhere upto two years or more. Officers are on transfer and do not have any sense of ownership about the Commission's work. Amidst all this, the recent judgment by the Maharashtra High Court will hopefully jolt the sleeping department into doing its job.

The Bombay High Court, reading Section 47 of the Persons with Disabilities Act, has ruled on August 5th, that employees who develop psychosocial disability cannot be terminated from service on that basis. The bench comprised of AP

Shah and DY Chandrachud, who ruled that the employee should be either shifted to another post with the same payscale and service benefits, or create a supernumerary post until a suitable post is available.

A staff nurse, Ashwini Desai filed against the Chhatrapati Shivaji Maharaj General Hospital, Solapur. Working here from 1980, she developed schizophrenia in 1999. She was asked to resign in 2003 on the ground of schizophrenia. She complained to the Disability Commissioner, Maharashtra and following his order, the Sasoon Hospital certified her 'unfit' to work as a staff nurse. KEM too submitted a similar report. On the basis of the certification of legal incapacity to work, the Disability Commissioner rejected her complaint in February 2005. His comment was that while section 47 grants right to continued employment, section 33 does not offer any reservation for persons suffering from mental illness, and

therefore she was not eligible for benefits under section 47. Section 47 has been read to the convenience of the disability commissioner. A fundamental right to work has been subsumed under the contingency of reservation. The HC bench noted, "It must be remembered that a person does not acquire or suffer disability by choice. An employee who acquires disability during his service is sought to be protected under Section 47 of the act specifically. If such employees who acquire disability are not protected, both they and all those who depend on them will also suffer". Also, "... the commissioner committed a serious error in holding that the benefits of Section 47 are available only to categories of disabilities mentioned in Section 33".

Hopefully, this admonition by the HC will wake up the disability department into recognising the needs of persons with psychosocial disabilities.



## Study group on the UN Convention

### A Report

Action Aid International – India, the New Delhi office, has been supporting a study group on the Draft UN Convention on the Rights of Persons with Disabilities for a year. The study group has been facilitated by Professor Amita Dhanda, a legal researcher, teacher and activist in the field of disability and law. The Government of India was supposed to continually engage civil society on the proceedings of the Convention, which they have failed to do. This is the only active study group which is having a virtual participation in the Ad Hoc Committee meetings through the work of Prof. Dhanda. Prof. Dhanda

has been actively participating in the UN Convention proceedings through the Bapu Trust and the World Network of Users and Survivors of Psychiatry, a global alliance fighting for the rights of persons labeled mentally ill.

The objectives of the study group, which has met four times this year, are as follows:

- ✿ To have an active, cross-disability forum where the proceedings of the UN Convention Ad Hoc Committee Meetings can be shared as well as critically discussed

- ✿ To promote a cross disability dialogue on the rights and freedoms of persons with disabilities

- ✿ To build capacity among some disability leaders and create an informed group of people on the UN Convention

- ✿ To engage a community based group with international thinking and law making in the field of disability

- ✿ To have each member of the group connect the UN convention discussions back into their own community or advocacy work



❖ To enable an advocacy group to play a crucial role in disability rights before and after the Convention

❖ To pressure the government to play a more proactive role in the making of the Convention

Four meetings have been held so far before and after the 5<sup>th</sup> and 6<sup>th</sup> Ad Hoc Committee meetings, in the months of January, February, July and August 2005. The first two meetings were introductory, and described the process of the Convention. The other international instruments in the area of disability were described. The differences between the international instruments, such as Principles, Rules, Treaties and Conventions were clarified. The process of drafting the Convention, and the role of civil society (the Disability Caucus) was described.

India has adopted the dualist method of law making, over the monist method. In a monist method, an international legal instrument is directly implemented in the country state. In the dualist method, a country develops a domestic law in consonance with the international law.

The need for a new Convention on the rights of persons with disabilities was detailed. Other conventions (such as CRC, CEDAW, etc.) have not worked in the case of disabilities. Where disability is mentioned in these conventions, the diversity of people with disabilities has not been recognized. Also, the perspective with which disability has been treated in these conventions has not been very progressive. The treatment of disability has been unimaginative and conventional. Remarkable also, was the near total lack of representation of persons with disabilities or organizations representing them in the making of these conventions.

The Convention on rights of persons with disabilities aims to be aspirational, bringing in a new era of thinking on disabilities. The stated

purpose of the Convention is “to ensure the full, effective and equal enjoyment of all human rights and fundamental freedoms by persons with disabilities”. The Disability Caucus is representational of persons with disabilities, including international organizations of all disabilities. WNUSP, the World Network of Users and Survivors of Psychiatry ([www.wnusp.org](http://www.wnusp.org)) is a part of the Disability Caucus, representing the needs and demands of persons with psychosocial disabilities.

The international instruments on ICCPR and ICESCR have hitherto dichotomized the realm of rights into the civil political and the socio economic. Civil political rights (e.g. right to liberty) are immediately justiciable and are often linked to constitutional rights. Whereas the socio economic rights are “progressively realizable”, i.e., as and when allowed by existing socio-economic framework of governments. However, every civil political right is linked with socio-economic right. For example, you cannot grant the right to liberty for persons with disabilities, without ensuring that the architecture and environment allows for free access and personal mobility. Granting CP rights without creating the necessary social economic infrastructure for realizing those rights is meaningless. To this extent, the present UN Convention runs the Civil Political rights with the Socio Economic rights in a criss crossing manner.

In the four study group meetings, we had an insider's view of the UN Convention work, and Dr. Dhanda facilitated indepth discussion on each Article of the Working Draft. As the 7<sup>th</sup> session of the AHC begins this January, the new reworked draft of the Chair person will also be discussed.

Brief report by Bhargavi Davar, Pune.



## ■ Drug Tracks

Sharon Begley [[sciencejournal@wsj.com](http://sciencejournal@wsj.com)] recently wrote in the *Wall Street Journal* (Nov. 18, 2005), after reviewing research, that around 19 million people in the U.S. suffer from depression in any given year. However, for many, SSRIs (Selective Serotonin Reuptake Inhibitors) help little, if at all.

According to the writer, to do better, we have to first get the science right. Anti-depressant advertisements promote the idea that these drugs supply the brain with additional Serotonin, to make up for an assumed chemical deficiency. But a review of scientific studies show that “Not a single peer-reviewed article ... support[s] claims of serotonin deficiency in any mental disorder.” In March, a review of decades of research concluded that something other than “changes in chemical balance might underlie depression.”

It is impossible to estimate the levels of serotonin in the brain. Other indirect methods are used, not always with predictable outcomes. There is now some evidence that SSRIs probably result in neurogenesis, i.e., the birth of new nerve cells.

It is worrying, given the poor evidence base, why people, especially children and adolescents, are getting more drugs than psychotherapy. Evidence suggests that psychotherapy must be the first line of treatment for childhood depression, and that relapse is higher with drugs for adults than with psychotherapy. It is also proven that psychotherapy is as good as drugs in treating depression.

The hegemony of the serotonin hypothesis may be keeping patients from a therapy that will help them more in the long term.

## Round Tables on Good Practices in the M.H.Sector, Gujarat

Good practices as a concept, is not widely discussed in the Mental Health Sector. The “Round Tables on Good Practices in the Mental Health sector in Gujarat” was a series of 5 consultations organized by the Center for Advocacy in Mental Health, a research center of Bapu Trust, Pune, to discuss this important issue. The objectives of the Round Tables were:

- √ To introduce values and principles in the MH sector, which will standardise care in the Gujarat Mental Health system.
- √ To develop ideas about practices that will protect the rights of users of Mental Health / psychiatric care.
- √ To have a common minimum understanding amongst all stakeholders about expectations and standards in mental health care.
- √ To initiate a multi stakeholder dialogue on mental health systems reform in Gujarat.

The first session in the series was held on Sunday 28th August 2005, at AMA, Ahmedabad. The workshop was attended by 30 professionals across various disciplines such as social work, community health, medicine, clinical psychology, psychiatry, carer’s groups and NGOs working on issues related to women, disability etc. As users are not mobilized in the country in general, and in the State of Gujarat, it was felt unethical by the organizers to invite individual users, as their risk of victimization was considered to be high.

Dr. Anil Shah, a senior psychiatrist from Gujarat, was the guest of honour. Dr. Bhargavi Davar, the facilitator of the workshops, welcomed the participants and briefed about the concept behind

these consultations. Dr. Shah, in his inaugural speech, traced the history of psychiatry in India, from a marginalised and neglected stream of medicine to a well researched, well practiced discipline. He highlighted the need for developing good practice guidelines in the field of mental health, which are congruent with clients’ expectations, culture, level of understanding and also the need to involve users and carers in this process. Given the diversity of disciplines and actors in the mental health sector, represented in this consultation, it may be challenging to arrive at consensus. However Dr. Shah in his closing remarks mentioned that the same diversity can be used to generate a variety of options, thus making this whole endeavour, a milestone in the history of mental health in India.

The facilitator made a presentation on the involvement of Bapu Trust in Gujarat government’s initiative in strengthening the Mental health Sector. Bapu Trust was a core group member of the team, which brought out the Mental Health Mission report (2003). GoG then created the Mental Health Support Programme (MHSP) to facilitate mental health services and interventions in the State. A report of these consultations will be forwarded to the Government of Gujarat for its approval through the MHSP programme.

The process of arriving at Good Practice in the mental health sector was described by the facilitator. The process consisted of first listing down a core value related to the field of Mental health, followed by theoretical explanation on the principles and evidence base supporting the same. Evidence refers not just to the medical research, but a wide range of

research and experiences available at the community level.

The Mission Report had identified the following core values as influencing the sector: Wellness, Safety, Honour, Justice, Participation and Autonomy. Defining a strategy to translate or apply this value into a clinical program or practice and then, defining a behavioral action at the client-provider interaction level, are the last steps in this process. The process may be described as follows:

**Value >> Evidence Base >> Strategy >> Behavioural action**

To further clarify this process, participants were asked to write down an example of a good practice that they follow in their work, along with the supporting evidence and the underlying value. Many examples were collected from the participants.

This was followed by a group exercise where participants discussed a list of reasons/statements that can be used as justifications for the process of developing good practices in M.H. for the state of Gujarat. The participants, initially felt constrained by non-availability of resources and lack of implementing machinery for good practices in M.H. However the facilitator urged the participants to overcome the practical aspects and discuss what we want ideally. Principled visioning in the client’s interest over pragmatics was given as the main objective of these consultations.

The group arrived at the justifications for good practices, enlisted below:

1. Having Good Practices guidelines will improve the quality of care in the mental health system. It will enhance the performance of MH system in fulfilling its objective of

providing a range of services, including preventive, promotive, outreach and curative services.

**2.** Having Good Practices guidelines will help in the regulation of the mental health service delivery system, so that it serves the needs of mental health service users in a standardized manner.

**3.** Good Practices guidelines are needed in order to customise MH services to meet the diverse and individual needs of users.

**4.** Good Practices guidelines will ensure that the best possible and the most effective service is given in a timely and cost effective manner.

**5.** Having Good Practices guidelines will result in the improvement of the quality of client - provider communications.

**6.** It will lead to better access to mental health information by service users and the community at large.

**7.** It will enable the community to make informed choices from a spectrum of available services.

**8.** It will bring greater accountability and transparency in the mental health sector.

**9.** It will lead to the creation of new services and ensure that many alternatives to existing services will be made available to services by service providers.

**10.** There will be more satisfied users if good practices are assured by mental health workers, both medical and non-medical.

**11.** Good Practices will lead to the optimal use of available resources and the creation of new resources.

**12.** It will ensure that the human rights of users are protected, including their protection from unsafe and hazardous practices.

**13.** Good practices will ensure a

pathway for the speedy and appropriate redressal of users' grievances in the case of violations.

**14.** Having such guidelines will result in the greater professionalisation of the mental health service system, bringing in more tools and instruments for the proper delivery and the monitoring of services.

**15.** It will enable an environment for the creation of a variety of new service options.

**16.** It will lead to more research in the field and creation of knowledge, especially on the social determinants of mental ill health and the effectiveness of a variety of mental health interventions, both medical and non-medical.

**17.** It will motivate all mental health workers, both medical and non-medical, to upgrade their knowledge and skills.

**18.** It will result in a greater clarity of roles and the better integration of all professionals in mental health service delivery.

Participants went on to enlist a number of important values that they hold dear. Some examples of value include respect, dignity, safety, confidentiality, autonomy, liberty, self determination etc. The characteristics of values were then discussed by the facilitator. This helped to define, enlist and operationalise values and make them more tangible and applicable. These values can be conflicting in some situations and may need to be prioritised. However the same value can mean different things to different people and can be accorded different importance by different stakeholders. e.g. 'honour' as a value may be held in high importance by user and carers, but not so much by the professionals. So in order to resolve dilemmas plaguing the mental health sector, it is important to have representations and discussions amongst various stakeholders around values.

The facilitator then listed down the principles of good practices and areas for operationalisation of the same. These principles were based on the core values in the field of M.H. The principles agreed upon by the group are as follows:

### **Wellness**

*Principle 1:* Interventions provided will match the individual needs and will be in the best interest of the client.

*Principle 2:* Every client will be offered a variety of well researched, effective interventions.

*Principle 3:* The client's holistic health will be considered in delivering appropriate mental health interventions.

### **Participation**

*Principle 4:* Steps will be taken to facilitate and ensure client participation in the intervention process including design, plan and implementation of services.

*Principle 5:* Services will be accessible and affordable.

### **Safety**

*Principle 6:* All interventions will ensure the safety of clients.

### **Honour**

*Principle 7:* Culturally appropriate treatments will be provided in the best interest of the clients.

### **Autonomy**

*Principle 8:* The client will lead the choices made in her / his own care and treatment.

### **Justice**

*Principle 9:* Services and interventions will protect the civil, political, social, economic and cultural rights of clients.

*Continued on p 15*



## Chicken for the Soul

Swati Joshi

From the diary of a researcher

It was my first day of data collection. I thought that I had an open mind before entering the Hospital for Mental Health, Baroda, but I was mistaken. My presumptuous mind did not support my hurried footsteps. Undertaking a research on mental health, reading up on the objectives and formulating a tool did not make me as sensitive to mentally ill people as I had thought I was, until I met Sailesh.

I waited on a bench in the waiting room as my co-researchers were talking to a respondent. Sitting beside me were visitors (old parents) waiting for their son to come from the male ward. Sailesh a tall, slim man around 30 years of age approached excitedly with gleaming eyes and a smile on his face. Accompanying him were a few of his inmate friends, to whom he had proudly announced the visit of his parents.

My eyes could not move, they were glued to watching him. He soon noticed me and walked up to me in curiosity from where he was sitting (affectionately between both his parents on the bench.)

"Good morning, *ben*", he said to me. "*Mara mother father*" (my parents) he said pointing towards them. I

nodded. Not convinced with my response shouted, "MOTHER", "FATHER", "*mara mummie pappache, mari mulakate avya che*" ("these are my parents and they have come to visit me.") With loads of energy Sailesh wanted to tell all that his parents had come to visit. His happiness knew no bounds and this was reflecting on his face.

Sailesh went to his mother and spoke softly in anticipation, "*Where is the chicken you promised to bring the last time you visited me?*" His mother's face turned white. She had no chicken and she had no answer. Sailesh again asked, "*Where's the chicken? Give it to me fast*". Trying to cool down Sailesh's excitement his dad gave him the hot *bhajiyas* they had brought for him. But this did not pacify him. Sailesh was heartbroken. I could feel his pain and the instantaneous change in his mood within fractions of a second. With tears in his eyes, he angrily asked for an explanation. His mother told him that the festival of Navratri was on. "*We are Brahmins, we cannot cook non-vegetarian food these days*", she said.

"*But you promised me*", he screamed. "*Why did you both come to meet me if you did not want to bring chicken for me? What will I tell my friends? I was waiting for the chicken, not for you. The festival of*

*Navratri is for you, not for me. You live at home. For me, everyday is just another day. There is no Navratri, no festival for people like me who live within these huge walls in the hospital.*

My heart sank. I did not know where to look. His parents were dumbstruck and could not meet Sailesh's eyes. I wanted to rush out and bring Sailesh some chicken. But, it was in vain. I was immovable. Ultimately, I was just a helpless spectator of a painful situation, which tore Sailesh's heart. Desire to have chicken. Was it too much to ask?

Months have passed but the incident remains fresh in my mind. Every time I get upset when I cannot get to eat what I desire, I ask myself, "*Is your desire to eat what you like more than the desire Sailesh had for chicken that day? Are you as heartbroken as Sailesh was?*" "No", is always the answer. My pain was much less than Sailesh.

That incident did not stop my life. But it was a lesson for a life time. Sailesh touched my soul. Somewhere in my life I was a different person.

*In "Women's experiences of mental health services: A case study from Gujarat". Report by Shagufa Kapadia, Renu Khanna and Bhavna Mehta, 2005, WOHTRAC, Baroda.*



Continued from p 14

By the end of the session, participants gained more clarity about the nature of good practices, the need for the same, the vales informing M.H., decision making and the process of defining and operationalising good practices. Participants agreed upon the four suggested themes in Mental Health

field where good practices need to be developed viz.

1. Institutional care 2. Community care & rehabilitation 3. Medical care and treatment & 4. Medical opinion and legal capacity.

The session ended with a round of feed back. Participants found the whole exercise challenging and

stimulating and expresses their commitment to the future discussions. Dates were finalized for the other GP Round Tables.

*The workshops were designed by Bhargavi Davar of Bapu Trust. The report of the Round Tables is being prepared by Aparna Joshi, Bapu Trust, Pune, August 2005.*



## Tell it to a shrink

Song by Morgan Firestar,  
*Madness Network News*,  
 1982,  
 Vol. 6, No. 5, p. 23.

If you are looking to tell your troubles to a man  
 Who puts you down,  
 If you are hoping to find a part of your mind  
 That will turn your life around,  
 If you want to be like all the rest,  
 And you are looking for someone who always knows best,  
 If you want to change without having to think,  
 Don't talk to me about it, tell it to a shrink.

Oh, I,  
 I don't believe, that there's anything you need  
 But the freedom and the space to belong to the human race,  
 And I don't care to listen to the attributes you  
 Say you are missing,  
 If you buy the tales they tell,  
 Please tell me why they can't make you well.

If you are trying to find an answer in the magic of pills,  
 If the opinion of your doctor cures more than it kills,  
 If you feel that in your desperation  
 You'll settle for your mind's obliteration,  
 If you don't mind spending your life in the clink,  
 Don't talk to me about it, tell it to a shrink.

A shrink, he loves to hear, all your anguish and your fears,  
 As long as you take the blame for how you feel  
 He'll play the game,  
 I know that your future's at stake,  
 But there's a step I cannot make you take,  
 If the days ahead don't make you brave,  
 You can talk yourself into an early grave,

But if you are looking for the freedom that only  
 Truth can provide,  
 If you are willing to put aside what you have learned  
 And keep an open mind,  
 If you want to try your wings and fly,  
 I'll tell you, once, so did I,  
 And when I listen, you will know my interest is real...  
 I know how you feel.

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