# UPDATE
## News and Notes

# Strengthening the Cuckoo's Nest?

## A Comment on Mental Health Bill

FREUD and subsequent psychoanalysis, psychotherapy and psychiatry have radically changed the worldview with regard to mental health and illness. Western capitalist countries and socialist countries have largely accepted these changes and have evolved structures and legal provisions that provide a relatively better deal to the mentally ill. However, in all these countries the changes have been within the overall framework of social control, which was anyway the purpose of feudal notions of 'lunacy'.

In India, as in most backward countries, the traditional 'lunacy' worldview is still dominant even within the modern legal framework. Mental health and illness in India was till last year governed by the Indian Lunacy Act of 1912 formulated under British imperialism.

The Indian Lunacy Act (ILA) incorporated only a one line definition of a 'lunatic'—"a lunatic is an idiot or a person of unsound mind"—but had as many as 46 sections dealing with how the property of a lunatic should be administered. Between the period of the enactment of the ILA and the new Mental Health Bill (MHB), passed by parliament in 1966, there have been significant global advancements in explaining, understanding and treating mental illness. But the new MHB in India provides only a cosmetic change over its predecessor. It condemns all mentally ill persons, excluding those mentally retarded, as criminals. The new definition of a mentally ill person is "a person who is in need of treatment by reason of any mental disorder other than mental retardation". Thus, apart from excluding the mentally deficient, the MHB is no different in its basic form from the archaic ILA.

Advances in psychotherapy, psychoanalysis and community mental health care, among other alternatives, are not even mentioned in the MHB. The wide range of mental illnesses is ignored. The monopoly of treating the mentally ill is given to psychiatrists who know very little about alternative therapies. For the psychiatrist chemotherapy and electric shocks or even psychosurgery are the only means for dealing with mental illness. Psychiatrists trained in India do not have any significant exposure to even psychotherapy (with the exception of perhaps those trained in NIMHANS), let alone psychoanalysis and other non-invasive alternatives.

This sole reliance on psychiatrists in the MHB will only further medicalise a problem that has largely social origins. Historically, it has been well established in psychological and sociological research that mental pathology stems largely from society itself. Poverty, exploitation, insecurity, alienation and above all class society itself are harbingers of mental illness.

In spite of this knowledge the MHB is no more than a provision for locking up and managing the property of the mentally ill. It is interesting to note that "property" forms the cornerstone of the MHB as in the case of the earlier ILA. For the imperialist powers the ILA was an important means of controlling and manipulating the power structure by dispossessing many uncompromising landed aristocrats and local power brokers of their property by invoking the provisions of the ILA through which any magistrate could declare a person mentally unsound (without any aid of a medical professional). What the MHB has done is to shift the onus of establishing mental "unsoundness" from the judiciary to the psychiatrist. Thus the enactment of the MHB is consistent with the dangerous trend of the general medicalisation process of human health—*it is more a police bill than a health bill.*

Though on the whole psychiatrists have been critical of the MHB and have demanded amendments, the Indian Psychiatric Society (IPS) has welcomed the medicalisation and the provision in the bill for admission of mentally ill patients to privately run psychiatric nursing homes, besides government owned psychiatric hospitals, which alone were authorised earlier to admit such patients.

In fact the main interest of the psychiatrists in pushing this bill was to gain this provision. This provision too is consistent with the general trend of privatisation. However, in the same breath the IPS has strongly condemned the provisions for licensing and inspection of private psychiatric practice by a state authority—the IPS plans to approach the supreme court to rid the MHB of this latter provision (but it will not challenge the MHB itself)!

Medicalisation and privatisation of mental health care will only worsen the situation for the mentally ill. Further, as regards rights of the mentally ill person there is only passing reference with regard to protecting the patient from 'cruelty' of a practitioner. But this toothless protection is overridden by the fact that the family, state and the medical profession have full control over the patient physically, mentally and socially. The decision-making about diagnosis, therapy, admission, treatment and discharge are vested in the patient's family and doctor. The patient has no say whatsoever in the matter. Therefore a patient suffering from a simple neurotic condition may easily face confinement if the family (for instance in a family property feud) or the state (for instance in case of an ideological adversary or a political prisoner) sanction so on behalf of the patient who supposedly is incompetent to make a decision about his/her well-being.

Thus on the human rights front the new MHB fails completely. If at all, it strengthens control over mentally ill persons clearly abrogating their fundamental rights and implicating them as stigmatised and unlawful citizens.

Hence the MHB needs to be challenged not only by psycho-professionals of all variety but also by civil rights groups, lawyers and social scientists. The MHB's basic form needs to be changed from a social control perspective to a human rights perspective Mental illness and health conditions need to be defined in detail and the independence of the mentally ill person needs to be protected. The protection should have a social basis, and under present conditions can be best ensured with the assistance of civil rights groups and the judiciary. All concerned, therefore must strive to make the MHB biased in favour of the mentally ill and not against them.

**Ravi Duggal**

## Indian Workplace: 'Safe', 'Clean' and 'Healthy'?

A BILL amending the Factories Act has been passed by the Lok Sabha some months ago. While the Bill for the first time accords to workers some rights which had hitherto never been recognised, it needs to be dissected thoroughly. For the present it is interesting to note that even those rules regulations and norms which have been in force for decades continue to be ignored or openly flouted. Take the case of reporting of accidents and occupational diseases. Anyone looking at the data presented year after year in the *Indian Labour Journal*, the official publication brought out by the Ministry of Labour, would marvel at the safe, clean and healthy environment in Indian industry!

Take a look at the accident figures for three years—1981, 1982 and 1984 (the latest). In 1981 there were a total of 3,41,423 injuries of which 740 were fatal. In 1982, 3,02,268 injuries of which 599 were fatal and in 1984 there were only 1,15,442 injuries of which only 381 were fatal. Data was not available for 4 states in 1981, for 5 states in 1982 and for 9 states in 1984. While the figures are not strictly comparable because of inadequate reporting, it is interesting that the proportion of fatal accidents is less than 0.5 per cent in all the years. The accident rate, as everyone but the very naive knows, is extraordinarily low and is in no way related to the real situation. Injuries are reported only when a worker is incapacited by them and thus a large number escape being recorded.

The case of the non-recording of occupational diseases is even more interesting. In 1981 there were 13 reported case of ODs, all of them being chrome ulceration. In 1982, there was a sharp jump in OD with 101 cases—with apparently an epidemic of silicosis (87 cases), all from Madhya Pradesh! In 1984 there was a sharp drop to 27 cases and all of them chrome ulceration again. Even more interestingly, the only state being troubled by OD was Maharashtra for no cases of OD were reported from anywhere else in the country! That the case reporting either of accidents or of ODs is atrocious has been highlighted in these pages some years back (*SHR*, Vol I:3). The article on 'Illness and Accident Reporting in Industry' had pointed out that the reporting has consistently declined since 1960. But is this very surprising given the fact that the number

of medical inspectors of factories had been 11 in 1981, went up to 42 in 1982 and down again to 10 in 1984? Given this kind of situation, what role do amendments ostensibly strengthening the Factories Act play—especially given the fact that workers' health has not been a prime concern in the labour movement in India so far?

PP

## Eyesight Problems Among Workers

THE electronics industry is the largest employer in the production sector in Malaysia. Upto October 1986, there were some 70,000 workers, most of whom are women.

Eyesight problems are reported to be occurring frequently and at an alarming rate among workers in electronics factories. Those affected come from the semiconductor assembly section. The work here requires the workers to use microscope daily to tie wires to pieces of semiconductors which are almost invisible to the naked eye.

According to a survey published in the book, *Health Hazards in Electronics* by Thomas H Gassert, 44 per cent of the workers in American-owned electronics factories in Malaysia complain of eyesight problems while 42 per cent complain of headaches.

The survey revealed that the eyesight problems are due to the use of microscopes and TV monitors as well as exposure to chemical vapours, smoke and dust on a long-term basis.

Eye diseases such as conjunctivitis are caused by chemical vapours and can spread from one worker to another because the same microscope is used by several workers. This problem is made worse by the long hours of work. Salaries and bonuses are paid based on a quota system and the quality of work done. Hence, many workers may be driven to work hard, without sufficient time or rest.

The survey also found that many companies do not teach the staff the proper use of the equipment. Microscopes and TV monitors which are defective are also not repaired.

Noisy machines can also harm the electronics factory workers as the noises can lead to hearing loss and can cause tension which will lead to other health problems.

In electronics factories, some machines such as the metal stamping machines and the packaging machine are very noisy. The use of ultrasound to tie and test components also emits noise at a high level.

The safe level of noise, according to *Health Hazards in Electronics*, should not be more than 60 decibels and 16 kilohertz for an eight-hour working period.

The book says that loss of hearing among electronics factory workers is due to prolonged exposure to a noise level above 80 decibels.

This exposure can also cause tension which will eventually lead to other problems such as hypertension, increased heart-beat, vein disorder, irritability and a lack of concentration. All these in turn may lead to accidents at work, cause muscular tension, nausea and headaches.

*Utusan Konsumer*, March 1987

## Campaign to Ban Hazardous Drugs

THE Drug Action Forum, West Bengal has initiated an interesting campaign for a ban on the manufacture and sale of unscientific and harmful fixed-dose combination of chloramphenicol-streptomycin. They have been circulating a letter to manufacturers requesting that they stop manufacturing these products. The letter is signed by 270 practitioners of West Bengal and sets out the reasons why they feel a ban is necessary.

The letter points out (1) that the combination has not been recommended against diarrhoea in any standard textbook of medicine and there is no scientific basis for such use; (2) that chloramphenicol is a valuable drug, the drug of choice for typhoid and its indiscriminate use may cause the development of resistance to typhoid bacilli; (3) that streptomycin is not absorbed through the gastrointestinal tract and is besides a first line drug in the treatment of tuberculosis and is in perpetual short supply; and (4) that there are many effective alternative treatments for diarrhoea when needed.

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