PSYCHE AND SOCIETY

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CONTENTS

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Editorial

Dr. Nilratan Sarkar

"At the root of all evils lies our terrible ignorance - ignorance of the origins, nature, symptoms and course of the disease (tuberculosis), ignorance of the method of treatment of this disease, ignorance of the measures to be adopted to check its spread."

This was the realisation of Dr. Nilratan Sarkar, the doyen of Indian Medicine born on 1st October 2011 at a remote village of Diamond Harbour, 24 Parganas. So this year we are celebrating sesquicentenary of this great personality. In the quoted lines he is speaking of health-education the most neglected area of our health policy. Education and the spread of more rational attitude have a general bearing on health conditions. It is our duty to instruct people about specific health hazards as does the task of improving sanitation. Better sanitary facilities are among the most urgent needs in India, but unless standards of private hygiene are raised little effort will be made to provide them at local level, and where they are provided, they will not be properly used. Still in this 21st century fifty percent of our population are in the habit of open air daefecation!

Nilratan born in a poor family and struggled throughout his life facing various obstructions. Even in his last days he had to suffer due to heavy loss-debt for his innumerable enterprises. But he was so sensitive that whenever he got any opportunity to help a poor student suffering from poverty immediately he responded. Actually he had a sensitive mind and a sympathetic heart for his fellow travellers and he had deep love for his colonial, largely feudal society. After establishing himself as a physician he had started many things. He had started innumerable business companies, various educational institutions including clinical laboratory, medical college, Bengal Immunity drug manufacturing company etc.. He had performed research work like 'cirrhosis of liver in children'. This was the way and nature of that person to serve his countryman throughout his life. Naturally with this type of untiring work a man envisioned the root cause of all evils as poverty and we can conclude that he was restless seeing the dire poverty and wretchedness of his fellow countrymen. He was not satisfied with his work though he was a dedicated soul for the development of our health system. At least he had diagnosed the disease of this society the 'ignorance'.

There is no other way but to fix responsibility for this total dismal condition of the health system of our country, as bad heath planning. From colonial period to still this date there is no comprehensive health planning of our country.

But Nilratan was not a health planner and we do not know he had any opinion regarding health planning of this country. Over and above there was Dr. Roland Ross in Calcutta, the celebrated physician and epidemiologist who got the Noble prize for his works on Malaria. So it was possible to organise such type of works inspite of immense hurdle. But for this we need comprehensive knowledge and need of our society, people and environment.

Now we know to succeed in this physical planning we need more specific knowledge about facts and causal relatioships.There are importance of the inter-relationship among all the factors involved in the health problem of India, the various health deficiencies themselves, the prevalent environmental conditions, and the steps taken to prevent and cure illness. It is impossible to impute to any single measure or set of measures a definite return in terms of improved health conditions. We cannot achieve anything without taking account of circular causation within the health field and in the whole social system. Regarding recent logical criticism in terms of 'Human Resource Development' it is fact that there is only the frailest basis of knowledge about the factors involved and their causal inter-relationship. *PAS*

Modern Psychology and Alienation-Problem

Dhirendranath Gangopadhyay

Central problem faced by today's Psychologist is to search the cause of gradual increasing feeling of lonliness, helplessness and criminal attitude of mind of the individual psyche. World victorious, ageless man has made distance to near, made bridge over ocean-divided nations and continent but on the contratry he gradually became alienated from his society, from other men and he thinks his fellow men as his enemy. As a result of this vortex criminal behaviour, helplessness and lonliness develop inside man. "The world is more one than ever, and yet, man is more than ever divided." This is the characteristic of this age. Somebody calls it atomic age and some one calls it age of automation.

To a psychologist this is the age of alienation. Man is the chief enemy of man. "His enemy number one is MAN ... he has been transferred by man into a convict for their use." (Sartre) Today's man is highly suspicious and frustrated and he develops neglect and hatred against this society. Not only that. This alienated man is alienated from his self also. So he is ready to commit suicide. "These men are not merely rejecting life, many of them are anti-life." Colin Wilson in his book 'Outsider' has discussed the role of outsider in Western-European literature and comments that this age is exactly reflected in the character of outsider.

The hero of this age in the 'Outsider' fails to enter in the depth of life so he is alienated from life. There is no final purpose of this life. Only there are irregularities and indiscipline. It is useless to try for any unity. Standing far away from the society today's individual is peeping across some aparture of the closed door to the distant outside world as a detached spectator. Thus all of us are as if floating in the ocean of life like an isolated detached island.

It is not correct that there was no alienation in the Nineteenth Century or its before. But that alienated or outsider person were something different. There ideas were not reflected in the philosophy of that age. We could sympathesise them as ill persons. But the age beyond Freud, Darwin, Fresor, Einstien is judged by alienation as the character of this age. We do not consider this disorder of life and society, this alienation as some accidental phenomena or curable mental illness. It is emerging from the innate nature of man and that is his unchangeable inner character.

At least a group of psychologists of sixth decade of Twentieth century have this opinion. They consider alienation is as a natural, normal and universal phenomena and in this age of mechanization it has increased its length and breadth. Because what man has dreamt of the quality and human development that will not be fulfilled in the future. Because man's thought-behaviour all are without cause and effect relationship, uncontrolled, irrational, imbalanced. Because we are all guided by our irrational compulsive unconscious drives. And this "irrational compulsive unconscious drives" are the direct reaction of mind against the industrial capitalist society. It is impossible to discuss regarding alienation in modern psychology without a prelude of central hypothesis of neo-Freudianism or revised psychoanalysis. It is necessary to be aware of neo-Freudian opinion regarding analysis of alienation before we discuss the view

of Pavlovian psychology.

The educated elites of America and Western-Europe consider the hypothesis of this new psychoanalysis as an established progressive ideology. The leading personalities of today's art and literature specially the cinema and theatrical personalities are almost all influenced by this ideology. The chief characteristics of today's literature are the agony of man's alienation develop from the helplessness, criminal mentality, hypnotisable activities etc.. The rationality of man and his power of reasoning, his scientific views are all matter of laughing stalk. Man does not know who is he, why and where is he! The anxious individual encircled by this social situation of enemies gradually transformed into a self-centred, mindless, cruel machine for the expectation of security, self-protection, fulfillment of his organic demands.

In this capitalist society man has got the taste of individual freedom but his sense of security has been thwarted. "By losing his fixed place in a closed world man loses the answer to the meaning of his life; the result is that doubt has been fallen him concerning himself and the aim of life. He is threatened by powerful superpersonal forces, capital and the market. His relationship to his fellowmen, with everyone a potential competitor, has become hostile and estranged; he is free - that is, he is alone, isolated, threatened from all sides ... paradise is lost for good, the individual stands alone and faces the world." - This has been stated by a world famous neo-Freudian.

The freedom we enjoyed being free from the captivity of Feudalism is almost abolished today. This was negative freedom. But this freedom has some positive side. Growth of science and technology have dominated on nature. As well as the cognitive awareness regarding society was increased and individual-motivation was spontaneous. But in today's era of monopoly the spark of individual spontaneous motivation has extinguished, inspiration has diminished. "Monopoly capitalism is viewed as a colossal Frankenstein monster in the face of which all non-monopoly elements of the population are frightened, cowed and reduced to insignificance and more devastatingly to means for the end of accumulation of profits." (H. K. Wells) The positive character of freedom of capitalist society has completely vanished due to terrible force of monopoly capitalism. The people's psyche is ill due to pervarsion of helplessness and frustration. The future is completely dark.

The neo-Freudianism primaily accept the cause of alienation as the 'fetishism of commodities' and 'alienation of labour' as depicted by Marx, a revolutionary theory and in this way they are able to draw sympathy from the Marxists. Not only economic relations all interhuman relationships are shattered. "Instead of relations between human beings, they assume the relation between things ... Man does not sell commodities, he sells himself and sells himself a commodity ... As with other commodities, it is the market which decides the value of these human qualities, ... even their existences." (Fromm) Later the apostle of neo-Freudians, emphasied greatly on the negative side of capitalist society and comments that to get respite from this intolerable pain of the individual psyche in this monopoly capitalism he is denying straight forwardly the resolution of alienation and freedom.

Fear, helplessness, uncertainty are gradually numbing the vibrant mind. He has two alternative: "They must try to escape from freedom altogether or they can progress from negative to positive freedom." Either he can escape or he can become active to organise the positive elements. It is difficult to take the latter path by any individual of this society. So he has left any kind of rational positive organisation and becomes the victim of irrational comulsive

unconscious drives. It is mistake to think man as "rational being". Many days back what Freud had uttered the neo-Freudians are repeating the same thing. Though they are not considering the innate instincts, libido as the only 'irrational compulsive unconscious drives', but they are giving emphasis on the uncontrol social conditions of this capitalist society.

It is true that the alienation would not be extinguished without socialism. But it also not the solution if the production systems are under the full control of the working class. Chief apostle of this ideology is Erich Fromm, he writes, "Marx had underestimated the complexity of human passions. He did not sufficiently see the passions and strivings which are rooted in his main nature and in the conditions of his existence and which are in themselves the most powerful driving force for human development. He did not recognise the irrational forces in man which make him afraid of freedom and which produce his lust for power and destructiveness."

According to them we cannot solely depend on the honesty and revolutionary activities of the working class. Because they are also guided by the 'irrational compulsive unconscious drives' like other classes of this society and they are also alienated from feeling, thinking and doing. "The socialisation of the means of production would only substitute one compulsively motivated class for another, the working class for the capitalist class."

It is not possible for them to organise the leadership for healthy socialist society those who have yet not changed their mindset and developed their character. Each and every people of this ill society, all classes are stressed by alienation and they are neurotic. We cannot depend on them. Marx was ignorant regarding the unconscious drives so he had dreamt of abolition of alienation and establishing socialist society by the leadership of the working class. According to them " Marx maintained an oversimplified, over-optimistic, rationalistic picture of man." Neo-Freudians deny that it is possible to change their mindset if the external conditions are changed. All are guided by unconscious emotions. They are not controlled by rational intelligence. To analyse the alienation this 'revised psychoanalysis' is actually the new edition of innate instinctualism. It is the expression of unalloyed idealism.

In the hypothesis of neo-Freudianism man is simply an instinctual animal. His conscious mind is guided by the unconscious emotional drives hiden secretly in an compartment under an irrational cave. This emotion is ego-protective. To protect this emotion since early childhood from the noxious environment this emotion has increased to this size. Unsuppressable power of this unconscious drive is the controlling authority of our thinking, behaviour and motivation. This emotion is not the reflection of this present situation. This blind protective instinct is developed as a reaction to external situation. It is an useless planning to create a healthy society inTwentieth Century for this man who is an instinctual animal. None of this intelligence, rationality, power of judgement, activity of conscious man can influence this spontaneous instinctual drive. This society is ill. Each and every person of this society are alienated from their self and they are ill. It is to build castle in the air to change this society by this concerned persons.

The special production system and system of exploitation of this industrial capitalist society have created a far wide gap between man and society. Man became an alienated automatons and floating freely by the current of emotion. Alienation is creating in the mind the irrational compulsive unconscious tendency. And this tendency is increasingly alienating man. Now we have to judge whether the picture of this totally destructive, alienating capitalist society and each and every person are on irrational, compulsive unconscious, instinctual drive

and emotionally guided so that they are unable to resist this process of alienation - do this project is at all scientific?

Apparently it seems to be natural that this all-pervading negative project is self-evidently true specially for the middle class intelligentia.There is no wonder about it that even the philosopher, writer, author, psychologist will be easily attracted towards this project. "Unorganised, alone, and defenseless, crushed between the two giant antagonists and thoroughly confused by an endless maze of conflicting factors, contemporary society of middleclass must indeed appear to defy reason and to destroy all things human." We cannot ignore this statement of an American directly. But this project has been developed totally ignoring the internal contradiction of society. This project has been developed denying the conflict between human and inhuman social essence.

This is against the world-view of dialectical materialism to overemphasise the destructive tendencies of this environment. It is a defeated mentality to consider the destructive power as omnipotent and unsurpassable without analysing the contradiction of social or collective and individual man. According to scientific judgement it seems to be correct that in today's society contradictions have reached its peak. Man is at the crest of its creativity due to the influence of science and technology. He has infinite potentialities. On the other hand development of man of this surrounding of narrow private ownerships are limited and its actualisation is obstructed.

It is the introduction of that fierce contradiction due to an endeavour to organise the new force in the old system. Mutual opposition of 'content' and form is gradually increasing and its boiling point has reached to a point of explosion. Without this contradiction of mutual opposition it is impossible to advance. This contradiction is the basis of all change and advancement. We should not only comprehend one side of the mutually opposite forces that is negative destruction degeneration, dreadful side of this old system. We should evaluate the other side also. Conventional logic does not explain the causal factors of this change. The dialectical logic can only explain about the total change and advancement. Neo-Freudian is only seeing the totally destructive monster of this monopoly age as it is denying the dialectical logic. They have not been find out the power that can destroy the monster.

He failed to find out the principle thread of this change. So "The world then appears irrational, unpredictable and controllable, while the individual is doomed to live his life out in isolation, loneliness, ignorance, fear, anxiety and dread, with only immediate reactions of pleasure or pain to bear him up or weigh him down". This is the statement of one of the members of American Psychological Association addressing against the onesided view of the neo-Freudianism.

He has said that in this society we can find out various opposing forces of this project. "Capitalism contains as a contradictory aspect of itself the potential human resources and ultimate power to transform society and build socialism and eventually communism." The ways of abolishing alienation in a gradual process are implied in befitting manner of the new content of this society meant for the revolutionary changes of the form. The way previously suggested is the way to utopian socialism that depends on the development of individual will where social changes are unbiased. To humanise people the scientific socialism depends on the development of the positive forces of the society. They also depend chiefly on the social revolution. "The contrast is sharp between Fromm's latter-day utopian socialism based on

wishes and individual regeneraion and scientific socialism based on the ontological structure of social change reflected in the logical structure of the social sciences."

Neo-Freudian theory is embeded on idealism and its theory is irrational. Its objective is to obfuscate the contradiction of social reality. To imagine that everything is under control of irrational compulsive unconscious drives means to ressucitate fatalism. In the 'revised psychoanalysis' project man since birth is in distress and helpless and for self-preservation instinct he develops a self-deceptive, self-hypnotising pattern of emotional reaction. In this way a process becomes active to fight against the opposing forces of evil society and to control the opposing forces. This emotional pattern of 'ego-defense' developed its special characteristic mental type since childhood. If a child has to abide by all the orders of egoistic oppressive father then his ego should feel distressed. To save ego from this distress the child develops within itself this 'self-deceptive and self-hypnotic' emotional pattern.

Either he gives autosuggestion that 'Father is heaven, father is religion' and becomes a good boy like our 'Gopal' or becomes a naughty boy like 'Bhuban' and attacks each elders and everybody in this society including his 'aunt'. In the latter life they become respectively either good, sober gentleman, law abiding conformist citizen or become intolerant, protesting, nihilist, revolutionary etc.. One group of them become masochist and the other group sadist. So we get some irrational, compulsive, unconscious emotional automaton instead of man like rational, creative, humane.

We hear the echo of the project from Kierkegard, Rilkey, Nietsze, Kafka, Camus, Tennese Williams to modern philosopher-writers. Can not we prove the project as horrible from the picture as depicted by Huxley or Orwell or Packard in his modern book titled 'The Naked Society'? Who can deny that at least the American society is clearly infested by the robot-mentality? More we can say that American way of life is gradually pervading in some undeveloped, underdeveloped and socialist countries. If we want any poll opinion from our readers of daily newspapers we will find that majority of them are establishing this Freudian project.

It is true more or less for all the countries that a handfull of sadist with their various strategies are actually guiding at their will to millions of alienated automaton masochist. One group of sadist are trying to capture, rule and exploit the society. The opposing force is shouting slogans to capture the state machinary. At the act of beckoning by a group of leaders millions of lower class people, mascochist automaton are controlled. All of them are surrounded by this irrational compulsive unconscious emotional drives. The leadership and people are suffering from the same diseases.

This phenomena is certainly correct. But with this we cannot prove the Freudian project. Apparently securing majority by votes and the scientific truth are not the same thing. "Science does not proceed in this phenomenal, pragmatic, positivist fashion. The truth of a theory depends on its ability to account for all the facts by the least complex set of principles." Not only that, it is not suffice to give only explanation. Through analysing the incidents the theoreticians have to give hints of some probable methods to control this incidents by implementing this theories. Any mentally sound person should ignore the social theory that thwarted the development of human society, that create nihilism regarding future that only frustrate the present situation.

Erich Fromm or Colin Wilson suggested to go back to the past age of human emancipation, abolishing alienation and resurrection of humanism. They suggested to surrender to

'Eastern mystic', 'Zen Buddhist'. They suggested to avoid rationalism, intellectualism and they want everyday in anyway should free himself from science and technology.

Only exact and rational implementation of positive aspects of capitalist society we can radically change the nature and society and therefore can establish socialism. It is only possible to hear song of harmony if the productive forces can be freed from its old form and content. The revolutionary changes of the society is the precondition for radical change of the mindset. It is like day dreaming fantasy to make a plan of curing every person by Freudian catharsis or religion and establishing sane society by removing the unconscious drives. The social scientist and psychologist who believe in reflection theory and gradual development of consciousness make allegation against neo-Freudianism.

The Freudian concept of emotion is unscientific. Psychology cannot develop by ignoring the neural science. Psychology develops due to reflections of environment on brain. Science does not support this concept that all the qualities of man like knowledge, intellect, thinking emerge from the compulsive unconscious emotion. 'Intellect and idea' are under emotion or guided by emotion - this Freudian project is ridiculous to human consciousness and it is denied by neural science. Idea and emotion is mutually neutral and compartmentalised in the mind - this concept is wrong. According to the theory of reflection idea and emotion are the two original continuous stream of individual consciousness. They are continuous but oppositely running. The emotional reactions are not the source of rational intelligence on the contrary the emotional reactions are influenced by the rational intelligence. Temporarily according to preplan the rationality can be inhibited and emotion can be intensified so that man can be inducted and delerious. But after the resolution of temporary toxic condition immediately the emotional process comes under the control of rationality.

In this capitalist society there are thousand planned systems to make a person devoid of his rationality and emotion-driven robot. But even in American society all the people are not irrational, idiot, hypnotised, totally socially alienated automaton. Irrationality, compulsiveness and emotionality are not universal phenomenon even in that country. All encompassing and all pervading Freudian project of alienation is simply an imagination. We can site example of Linus Pauling, dramatist Arthur Millar, newsreporter Salisburry, even Erich Fromm - this people are not servant of irrational unconscious mindset. This is not correct that an American is either a conformist or a rebel non-conformist. There millions of people are expressive, creative, productive, expandable.

The anti-people power of American monopoly capitalism is certainly infinite yet ninety percent American possess a healthy mind. Many of them are serving the monopoly. But they are not influenced by any compulsive unconscious drive. They are guided by their rational intelligence. There is much difference between to serve the monopoly and guided by some unconscious drive for earning a livelihood or for fear of death or being an automaton. Compulsive behaviour of mentally ill patients are beyond any treatment in most of the cases. So erich Fromm suggested them to surrender to Zen-Buddhism to change their mindset. But if we are become helpless but to serve the monopoly due to lack of intelligence or to earn livelihood or for fear of death then there are remedy to get rid of this problem.

To get rid of alienation it is possible to appeal to their consciousness, rationality and intelligence. It is possible to eliminate their inferiority complex, helplessness with the assistance of objective rationality. As a collective effort of man in revolution it is possible to break

the change of bondage. This truth can be established taking from the instances of social history. With the help of science and technology we can established a balanced planned human society from where we can uproot the evil forces and its supporting instincts. This expectation is not mirage-deception. Society has not only the experiences of strike and trauma it has experiences of counter-strike also. " Where reformed analysis views society as a source of traumatic experience - the primary effect of which is to induce unconscious ego-defences, the reflection theory regards society as a source of human experience - the primary effect of which is to induce the mental qualities characteristics of men's conscious life." (H. K. Wells)

Idealistic neo-Freudian theory denies the rationality and self-determining power of man, denies that man can develop a planned society on the basis of equality and fraternity. They create the pain of alienation more acute with the mist of frustration an nihilism. It denies the dynamacity of history and social science. What they create the attitude of man can be said as 'Misery syndrome'.

There is high order of imaginative optimism of mechanical materialism at the opposite pole of this idealistic psychological attitude of nihilism. This is called 'Pollyana Syndrome.' This picture is everywhere bright and gorgeous.People here never suffer from any 'Misery syndrome' i.e. dpression or frustration. They think that what is happening is for the better and history is progressing in its own speed to attain its goal. The latter group opine that it is creating much more than what it is destroying. People suffering from 'Misery syndrome' give tremendous emphasis on negative side of this society so they help to intensify the social, political and economic alienation. On the other hand people suffering from 'Pollyana Syndrome' depict only the onesided view of positive part. So they completely forget their active role to resist alienation and they assist to extend the alienation. There is a group of people who want change of mindset and mental revolution avoiding social change and social revolution.

Another group is satisfied and welcoming only the inevitable social change and social revolution. They think that due to social revolution there would be change of environment and spontaneously mechanically there would be change of mind. So the alienation would be abolished. And the mechanical materialists ultrarevolutionaries think that this social change would automatically change our mind. So the alienation would be abolished, mental faculties would be emerged according to its own rules. They are reluctant to think regarding todays problems of alienation and releted mental disaster. Idealist psychologist depict the degeneration of this capitalist society as some horrible picture. They say that this contaminated virus of degeneration petrified every layer of this society so the whole society is become poisonous. Now it is better to purify ourselves by escaping to some hermitage.

And the mechanical materialist think that everything would be purified by the flame of revolution. Everything would be pure. So they have the only task to add fuel to the fire of revolution. Everything of this society are fit to be given up. Evrything of this society are waste product. Actually this two groups have the same opinion in this respect. The difference is that the people suffering of 'Misery syndrome' think that this horrible entangled society like Octopus is undefeatable and this alienation is permanent. And the people affected by 'Pollyana Syndrome' think that this monopoly exploited society has reached its crest of degeneration. All its power are exhausted. It would crumbled in one stroke and at the same time the vast foundation of a healthy society would be created. If there is any alienation or delerium it would be temporary. All problems will be solved after reaching the goal of socialism.

Is it fact? Do the existence-alienation problem of a person has been solved in a socialist country? Do the conflicts and contradictions between persons and person with society have been resolved once we reached the road to socialism? The most accomplished socialist minded person will not accept this. In any new society there are problems of economic developments as well as there are acute problems of development of mindset. The creation of the environment of abolition of alienation is not enough to abolish it. The change of mindset is not a simple mechanical process. The process of this change is a complex dialectical interaction. As we need in the sphere of education apart from school college all through development of training and apprenticeship process so we require new knowledge of psychology and its implementation for development of psyche and higher mental qualities. The environment of exploitation-free new society is not suffice as a condition to create this change of mindset.

Because in a post-revolutionary condition of a state there exist mutually antagonistic ideologies and mental attitudes. There also exist alienation and many inhuman evil virtues exist hidden in the psyche. Though it is true that any problem can be solved much more possible way in this society. And we have to keep in mind that even in socialist countries there are many stumbling blocks to eradicate the problem of alienation. We do believe that it would be completely abolished in more advanced society structure. The objective of dialectical materialist psychology is to avoid both this 'Misery' and 'Pollyana' syndrome. Because its world-view is completely different.

The psychologist who believe in theory of reflection know that our brain do not reflect the outer world mechanically. Mind is not the photograph of social reality. According to prior experience and precondition external stimulus excites the brain. Man is far more acquainted with the noxious destroying stimulus of this human society. This is not the task of common people to trace the direction of alienation by evaluating the social history. So naturally primarily they find the picture of horror of this society. But there is the existence of the otherside also. Before we can take the photograph of the opposite side of the moon it still exists. As we increase our knowledge so we increase our depth and breadth regarding our environment. The dialectical materialist psychology know the positive, constructive side of the society. He is not biased regarding analysis. Who can deny the gradual progress, evolution and history of human society?

Though it is also true that a group of people of today's society are alienated from this soil, production tools and implements, even from this world. As it is inevitable for the class-alienation so it is true for individual alienation. Today man-woman are alienated from themselves. Above all man is alienated from his self. "Man is alienated from himself, his aspiration separated from reality, his ideals from actuality, his life from creativity, direction and meaning. Though a group of writer-philosophers are exclaiming in agony but do we agree with the universality of this alienation? We have said earlier that the healthy state of mind has not abolished, it is expressing itself in newer form, in new perspective. According to psychology the feeling of alienation direct the means and ways to eradicate it from human mind. This direction comes from the deep internal ideology of the society, this is the power of the society. It is the duty and essential responsibility of todays' man to know this power of contradiction of opposite forces, to proliferate it and consciously, actively carry it to a point of explosion.

There is no contradiction of opposite forces and everything is destructive - this is an

unscientific deliberate propaganda against which each and every honest social scientist should protest. The other side, the one that carries forward the positive progress of man, is a combination of the control over nature through production and the knowledge of nature including man, embodied in technology, the arts and sciences." In the international arena there are many elements and forces available for federal system. I have discussed it earlier. Apart what do we see regarding the trend of history? We have crossed the road of poverty of our ancient society and now residing at the relative proverty of capitalist society. We are certain that the future world would be full of abundant. "Man has thus made great progress in overcoming his alienation from health, from knowledge and from beauty. But positively, he has developed tremendously his ability to produce, to control nature, to change the environment to meet his needs; to create works of art and architecture, to shrink space by vehicular travel and to know the world and himself through science."

If we do not see the negative as well as the positive side of the picture of this modern society then we will be misguided to choose the way to abolish alienation. Either like the Freudians we have to consider that the negative picture is only true and will surrender to some religious temple to abolish alienation and to emerge humanism. Or we will do economic-political revolution like the mechanical materialist proclaiming that alienation problem are meant only for the exploiters and intellectuals and it is not the problem of the working class. And thus we would ignore the human mind. In the first condition we would give tremendous emphasis on the individual and in the second condition we would consider individual as a mechanical part of the collective. It is our appeal to the first group that man has not been alienated due to biological evolution. The alienation problem of man is a specific historical condition and it depends on geographical locality and time. Today's depth and extension of alienation is the result of some specific incidents happened in specific time period in the history. As alienation is not universal so it is not true for all time.

And we would suggest to the second group that it is not to deny everything at the name of building socialism. We have to reject the unhealthy materials and to preserve the healthy materials of the past. "Either good or bad, either friend or foe," this kind of judgement is done by the mechanical materialist, not the dialectical materialist . Mechanical materialist has lost his credintial in the Nineteenth Century and modern science does not depend on it. We are facing alienation again we are searching the way out how can we abolish alienation. This is the truth of psychological sciences. As many time the common people would be acquianted with science then they would see the scientific way out of abolishing alienation.

According to psychological science, as man tries to join with others so he wants to dissociate himself from others and tries to envelop him into a shell of self. The first half of history of capitalism is the history of unchaining the person from the bondage of feudalism. It is the history of emergence of individual freedom, individualism and self-realisation. Again then only started the depth and extension of the feeling of alienation.

After few hundred years effort man has created a huge possibility of material abundance. Science has fortified the brain few thousand times and its muscle few million times. This effort has also intensified the condition of alienation. Individual has transformed into big. The feeling of piece and alienation have intensified into the individual essence. On the otherside due to collaborative activities in production he envisage the possibility of new amalgamation. He is trying to abolish the feeling of alienation may be the inividual man never wants to abolish the

individual essence. He does not want to amalgamate with the community just like previous days.

In near future in the era of socialism and in distant future in the era of communism there would be classless society where people will join together, the interhuman relationship will much develop and it will be more profound and rich. But there is no scope of abolition of individualism. The individuality will develop more but it would be collaborative. The scattered mind will completely join with the species being. Huxley or Orwell did not assume this kind of dialectical congregation. Fromm and Wilson also failed to do so. In every epoch man has done planned advancement of human society with his intelligence and judgement. So the development of socialism is also due to the conscious effort of man's mental quality. This mental qualities comprises emotion, feeling, intelligent, judgement, motivation amalgamated to form a collective effort.

Every country is trying there level best to abolish alienation. This effort is natural. It is flowing on in various ways. Ceremoniously and organisedly this efforts are done by the trade unions and by organisations of some interest with the same ideology. To eradicate the lonliness and helplessness of the individual this endeavour is very much successful.

Sometimes this organisations become weak due to conflict of interest and opposite ideological contradictions yet they are the solid camps of the individual persons to abolish their alienation. Due to various commercial bipartite or tripartite interest and contract there are less international conflicts among the countries. It would be wrong if we conclude that a great number of people of various countries depicting a frustrating picture of alienation and in turn it is making people as anti-struggle. The angry generation is attacking the state and the social system against the old rituals, dead cultures, existing values. The Bitonics are ridiculing the loyality or conformism. All this proves the depth and breadth of alienation. Again in some area we can find this as an hidden effort to abolish alienation though may be in right pathway.

Both the camps of progress and reactions are divided in many parts. The division of groups and subgroups naturally intensifies the animosity between man and separation among individuals. Individual revolt has become a rule now a days. In this critical juncture everybody is revolutionary specially the band of young and neo-youths. But it has a positive side. This kind of revolution introduces us to the development of individual and establishment of individualism. No body is ready to become a 'Mass-man'. Inner contradiction has reached its peak. It has now become impossible to adjust the new content in the old form. They are trying to come out being eccentric. But they are not confining themself in a small room of the hotel like the hero of novel 'Barabus'. They are reemerging remaining within the masses. The new form is searching its expression. They are expecting new-formation where individual and collective will collaborate themselves in a new way. Both due to the opposite centripetal and centrifugal forces they are sometimes bursting in rage and sometimes melting in sympathy. This ' historionic' endeavour and behaviour of them to meet together are nothing but the signs of abolishing alienation.

Somebody comments that alienation is the problem of the affluent society. It is the problem of the developed countries. Why we should call meeting and seminars to discuss about alienation in our country?

In answer we should say, yes it is the problem of the affluent countries but currently this problem is universal though not for all ages. So it should be discussed now and in future.

'Outsider' though not very common in our society but not exception. Abstract dramas are success in our society and there is 'antinovel' also. A number of articles regarding abstract art are being published in the magazines. The lonliness of the individual is depicted as pathogenic in poetry, short stories. This is creating contamination to the reader's mind. The social scientists find alienation as a causal factor of social economic disorder now rampant throughout the country. People are overcrowding at the clinics of the psychologists. In this perspective it should not be that much irrelevant to discuss the condition of our country according to development of modern science.

The psychologists who believe in the theory of reflection, think the problem of divisiveness is ceratinly the problem of the age. Though this problem has solution as this society can be changed. Only modern science can show the right direction of this solution.

[I am heavely indebted to H. K. Wells (1962) for using the quotations from his books.]

January 1967 PAS

Is Science Advancing?

J.B.S Haldane

The British Association for the Advancement of Science is meeting in Cambridge, and the Editor of the Sunday Graphic has asked me whether science is still advancing. A geneation ago everyone except a few cranks would have said. ''Yes'', without hesitation. But now people doubt it for two reasons. The science which we know is not being applied. What is the good of applying science to growing potatoes if you are fined for growing too many, as a Doset farmer was recently fined? New industrial processes are not applied because they, would involve scrapping costly plant. This is bound to happen when monopolism is introduced into industry by trusts, and into agriculture by marketing boards. Whoever is to blame for this state of affairs, it is not the scientist.

The other reason is that the public has lost touch with the progress of science. This is partly the fault of scientistis for not writing in a language that people can understand, and partly the fault of the public for being more interested in theories than facts. No theory lasts for ever. Forty years ago most physicists believed that material bodies moved through a fixed ether which transmitted light. On the basis of this theory radio communication was invented. Then Einstein showed that there was no fixed ether. But the radio stations did not stop working because the theory on which they are based had broken down. On the contrary, they work a little better because we have a better theory.

So in what follows I am going to describe some recent advances in science which deal with facts, not theories. That is to say, even if future generations describe them in different words, they will have to recognize their existence. I do not much care whether light consists of waves or a searchlight. I am interested in science not as a set of pretty theories, but as a means of controlling nature.

Let us begin with astronomy. For every hundred people who have heard discussions about the expanding universe (whatever that means) I doubt if one has read of the discovery made by Jansky, an American radio expert. He finds that there is a source of radio waves of about 15 metres length in the sky. These waves do not come from the sun or any of its planets,

but from the constellation Sagittarius, which we can see in the south on summer evenings. Men have studied the heavens with their eyes for thousands of years, and with telescopes for hundreds. Now at last we have a new instrument, and no one can yet guess what invisible things it may disclose.

Another set of radio experts, led by Professor Appleton, is investigating invisible things in our own atmosphere. Everyone knows that the waves from broadcasting stations are reflected down by layers in the upper air which are opaque to them, but let light through. A careful study of the reflection of signals sent out from King's College, London, and recorded at Hampstead, shows that below the lowest layer there are separate clouds invisible to the eye, but reflecting short waves. They have not yet been studied for long enough to know whether they will help us to predict weather changes, but this is quite possible.

To come still lower down, until five years ago people thought that a lightning flash was something simple and almost instantaneous. The Professory Boys invented a camera with a moving lens which showed that a lightning flash is about as complicated as a high jump seen on a slow-motion picture. It begins in the cloud, and comes down in a series of steps each about fifty yards long. At the end of each step there is a pause, and often a change of direction. When it gets to the ground, another much brighter flash starts moving upwards to the cloud. The whole thing is over in about one ten-thousandth of a second. But very often another pair of flashes along the same path start about a hundredth of a second later; and as many as twenty pairs may move along the same track. This knowledge is already being applied to protect the grid of electric power transmission lines from the effects of lightning.

Geography is a nearly complete science except for the Arctic Ocean and the Antarctic continent. There are no great new rivers and few new mountains to be found. But we have much to learn about the sea bottom. Biologists had long known that the animals and plants of Madagascar and India resemble one another, and therefore believed that they were connected by land in the past. The geologists were more doubtful until 1936, when a British ship making deep-sea soundings found a range of submarine mountains extending across the Indian Ocean, which may be the remains of a land which once united Madagascar to India.

Though we know a lot about the soil and rocks in most parts of the earth, until last year we knew nothing about the ocean-bed, except the mud in the top inch of it. Then an American scientist called Piggott invented a gun which is lowered to the bottom of the sea, shoots a brass tube down, and finally picks up a sample of the ocean-bed like the cores of rock which are removed when an oil well is being drilled. Samples of mud from the bottom of the Atlantic showed records of the past. The mud is largely composed of the shells of tiny animals like those found in chalk. But a few inches below the surface they are mixed with volcanic dust, perhaps from Iceland. Then come shells of animals now only found in the Arctic Ocean, but which lived in the Atlantic during the last Ice Age. In fact, the sea bottom is a record of the weather for millions of years back, except where currents are strong enough to drift the mud. Open part of the Indian Ocean is paved with lumps of rock containing manganese and other valuable metals. And at some future date it may pay to dredge these up from a depth of two or three miles rather than to mine for them.

These are some examples of progress in our knowledge of largescale things during the last five years. Now let us turn to smaller things. Not atoms, though. We have found out plenty about atoms in the last five years. And it is easy to give a theoretical account of them, but

it would take this whole article to describe a small fraction of the facts, which cannot be altered, whereas the theory is bound to be. Let us start then with chemistry, which takes the atom for granted. The biggest advances here are hard to explain in the space at my disposal. But there are plenty of practical applications too. One of the greatest has been the development of plastics, that is to say synthetic resins which can be moulded into any form. These have now been made so transparent that they will replace glass for many purposes. A lens of resin costs far less than a glass one, and is less brittle. In ten years I have no doubt that plastic lenses will be used instead of glass for most spectacles and field-glasses, though glass will hold its own for telescopes and microscopes.

The achievements of medical chemistry are still greater. Benzedrine is one of the most amazing drugs ever produced. It keeps one awake when fatigued, and speeds up various activities without causing mental confusion or physical clumsiness. It does not create addiction. However, like all drugs with any real effect, it is dangerous, for one thing because it raises the blood pressure. It is quite possible that it may have an unforeseen effect in a bolishing the examination system. A number of London students got first classes on benzedrine this year, and when this becomes common and a few dozen have killed themselves we professors will probably have to devise some better tests of ability.

Another valuable but dangerous group of drugs are prontosil and other derivatives of sulphanilamide. They cure certain kinds of abscesses, and infections such as puerperal fever and gonorrhoea in a few days. But they are dangerous. They often make the patient ill and sometimes kill him. No doubt experience will make them a good deal safer. Some drugs of this kind have been tried on these cancers which are common in old mice. And some of them seem to have been cured. However, it is still too early to predict whether they will be any use against human cancer.

The physiologists have probably found out how a nerve stimulates a muscle to contract. At any rate they have got near enough to the truth to be able to treat those kinds of paralysis in which this particular link in the chain between brain and muscle has broken down. Unfortunately the effects of a single injection of the curative drugs only lasts for a few hours. But the time will probably be extended, and meanwhile the patients can at least move their limbs normally for some hours daily.

A number of diseases such as smallpox, measles, and infantile paralysis are caused by agents far too small to be seen by the microscope. Stanley in New York prepared the first of these in a pure state, and Bawden, Bernal, and Pirie have investigated a number of them in England. In some respects they behave like living things, in others like inert chemicals, and they actually serve to bridge the gap between the living and the non-living, and to throw light on the problem of life's origin.

Other gaps in the story of evolution have been bridged by a study of fossils. The great South African palaeontologist Broom has found intermediates both between reptiles and mammals, and between monkeys and men. Stensio in Norway has similarly bridged the gap between fish and amphibians such as the newt. One great difficulty in Darwinism remained. A greyhound and a bulldog look more different than a horse and a donkey. But they will breed together freely, and the hybrids, unlike mules, are fertile. So critics of Darwinism thought that only varieties, but not species, could be produced artificially. However, Koshevidnikov in the Soviet Union has now produced a new species of fly. It breeds true, but when crossed with

the species from which it is derived it gives practically no offspring (to be accurate, one for every thirteen thousand produced by matings within the old species). Unfortunately it would take several centuries to produce a new species of dog by the same method. But there is no reasonable doubt that it could be done :

These are a few samples of the progress of science in the last five years. Some people will say that they are trivial, that are no scientists to-day of the calibre of Harvey, Faraday, or Rutherford, let alone Newton and Darwin. I do not agree. But the work of great men is so novel that it takes a generation to assess its value, and it cannot be summarized in a single paragraph. So I have not even mentioned half a dozen men, of whom posterity will perhaps regard three as men of outstanding genius, and the other three as hopelessly muddleheaded. I have my own views, but I may be wrong.

Scientific progress could be much quicker. But if young chemists cannot get jobs for research on drugs, but can readily get them for secret work for military or industrial purposes, this fact is bound to slow it down. It is up to the people to see that research is concentrated on branches of science which are likely to be useful to the community. And if this is not done they cannot justly blame the scientists if science does not advance as quickly as it might.

PAS

The Ex-Communist's Conscience

Isaac Deutscher

[We reproduce below a review article on *The God That Failed* (1949) written by Isaac Deutscher (1907)-67), an independent Marxist of Polish origin who later settles in the UK. Besides the biographics of Stalin and Trotsky, he wrote a number of penetrating studies on world situation.

The God That Failed, edited by Richart Crossman, a British MP, contained the ''confession'' of some ex-communists and fellow travellers such as Louis Fischer, Andre Gide, Arthur Koestler, Ignatio Silone, Stephen Spender and Richard Wright. The book was meant to be a weapon in the Cold War and was accordingly translated in several languages, including Bengali. We feel that Deutscher's point is still valid although the book he reviewed in 1951 has been justly forgotten.]

Ignatio Silone relates that he once said jokingly to Togliatti, the Italian communist leader : 'The final struggle will be between the communists and the ex-communists,' There is a bitter drop of truth in the joke. In the propaganda skirmishes against the U.S.S.R. and communism, the ex-communist or the ex-fellow traveller is the most active sharp-shooter. With the peevishness that distinguishes him from Silone, Arthur Koestler makes a similar point : 'It's the same with all you comfortable, insular, Anglo-Saxon anti-communitst. You hate our Cassandra cries and resent us as allies – but, when all is said, we ex-communists are the only people on your side who know what it's all about.' ... Now six writers – Koestler, Silone, Andre Gide, Louis Fischer, Richard Wright, and Stephen Spender – get together to expose and destroy *The God That Failed*.

The 'legion' of ex-communists does not march in close formation. It is scattered far and

wide. Its members resemble one another very much, but they also differ. They have common traits and individual features. All have left an army and a camp – some as conscientious objectors, some as deserters, and others as marauders. A few stick quietly to their conscientious objections, while others vociferously claim commissions in an army which they had bitterly opposed. All wear threadbare bits and pieces of the old uniform, supplemented by the quaintest new rags. And all carry with them their common resentments and individual reminiscences.

Some joined the party at one time, others at another; the date of joining is relevant to their further experiences. Those, for instance, who joined in the 1920s went into a movement in which there was plenty of scope for revolutionary idealism. The structure of the party was still fluid; it had not yet gone into the totalitarian mould. Intellectual integrity was still valued in a communist; it had not yet been surrendered for good to Moscow's *raison d'etat*. Those who joined the party in the 1930s began their experience on a much lower level. Right from the beginning they were manipulated like recruits on the party's barrack squares by the party's sergeant majors.

This difference bears upon the quality of the ex-communists' reminiscences. Silone, who joined the party in 1921, recalls with real warmth his first contact with it; he conveys fully the intellectual excitement and moral enthusiasm with which communism pulsated in those early days. The reminiscences of Koestler and Spender, who joined in the 1930s, reveal the utter moral and intellectual sterility of the party's first impact on them. Silone and his comrades were intensely concerned with fundamental ideas before and after they became absorbed in the drudgery of day-to-day duty. In Koestler's story, his party 'assignment', right from the first moment, overshadows all matters of personal conviction and ideal. The communist of the early drafts was a revolutionary, before he became or was expected to become a puppet. The communist of the later drafts hardly got the chance to breathe the genuine air of revolution.

Nevertheless, the original motives for joining were similar, if not identical, in almost every case : experience of social injustice or degradation; a sense of insecurity bred by slumps and social crises; and the craving for a great ideal or purpose, or for a reliable intellectual guide through the shaky labyrinth of modern society. The newcomer felt the miseries of the old capitalist order to be unbearable; and the glowing light of the Russian revolution illumined those miseries with extraordinary sharpness.

Socialism, classless society, the withering away of the state – all seemed around the corner. Few of the newcomers had any premonition of the blood and sweat and tears to come. To himself, the intellectual convert to communism seemed a new Prometheus – except that he would not be pinned to the rock by Zeus's wrath. 'Nothing henceforth (so Koestler now recalls his own mood in those days) can distrub the convert's inner peace and serenity – except the occasional fear of losing faith again. ...'

Our ex-communist now bitterly denounces the betrayal of his hopes. This appears to him to have had almost no precedent. Yet, as he eloquently describes his early expectations and illusions, we detect a strangely familiar tone. Exactly so did the disillusioned Wordsworth and his contemporaries look back upon their first youthful enthusiasm for the French Revolution:

> Bliss was in that dawn to be alive,
> But to be young was very heaven!

The intellectual communist who breaks away emotionally from his party can claim some noble ancestry. Beethoven tore to pieces the title page of his *Eroica*, on which he had dedicated the symphony to Napoleon, as soon as he learned that the First Consul was about to ascend a throne. Wordsworth called the crowning of Napoleon 'a sad reverse for all mankind'. All over Europe the enthusiasts of the French Revolution were stunned by their discovery that the Corsican liberator of the peoples and enemy of tyrants was himself a tyrant and an oppressor.

In the same way, the Wordsworths of our days were shocked at the sight of Stalin fraternizing with Hitler and Ribbentrop. If no new *Eroicas* have been created in our days, at least the dedicatory pages of unwritten symphonies have been torn with great flourishes.

In *The God That Failed*, Louis Fischer tries to explain somewhat remorsefully and not quite convincingly why he adhered to the Stalin cult for so long. He analyses the variety of motives, some working slowly and some rapidly, which determine the moment at which people recover from the infatuation with stalinism. The force of the European disillusionment with Napoleon was almost equally uneven and capricious. A great Italian poet, Ugo Foscolo, who had been Napoleon's soldier and composed an *Ode to Bonaparte the Liberator*, turned against his idol after the Peace of Campoformio – this must have stunned a 'Jacobin' from Venice as the Nazi-Soviet Pact stunnd a Polish communist. But a man like Beethoven remained under the spell of Bonaparte for seven years more, until he saw the despot drop his republican mask. This was an 'eye-opener' comparable to Stalin's purge trials of the 1930s.

There can be no greater tragedy than that of a great revolution's succumbing to the mailed fist that was to defend it from its enemies. There can be no spectacle as disgusting as that of a post-revolutionary tyranny dressed up in the banners of liberty. The ex-communist is morally as justified as was the ex-jacobin in revealing and revolting against that spectacle.

But is it true, as Koestler claims, that 'ex-communists are the only people ... who know what it's all about'? One may risk the assertion that the exact opposite is true: Of all people, the ex-communists know least what it is all about.

At any rate, the pedagogical pretensions of ex-communist men of letters seem grossly exaggerated. Most of them (Silone is a notable exception) have never been inside the real communist movement, in the thick of its clandestine or open organization. As a rule, they moved on the literary or journalistic fringe of the party. Their notions of communist doctrine and ideology usually spring from their own literary intuition, which is sometimes acute but often misleading.

Worse still is the ex-communist's characteristic incapacity for detachment. His emotional reaction against his former environment keeps him in its deadly grip and prevents him from understanding the drama in which he was involved or half-involved. The picture of communism and stalinism he draws is that of a gigantic chamber of intellectual and moral horrors. Viewing it, the uninitiated are transferred from politics to pure demonology. Sometimes the artistic effect may be strong – horrors and demons do enter into many a poetic masterpiece; but it is politically unreliable and even dangerous. Of course, the story of stalinism abounds in horror. But this is only one of its elements; and even this, the demonic, has to be translated into terms of human motives and interests. The ex-communist does not even attempt the translation.

In a rare flash of genuine self-criticism, Koestler makes this admission :

As a rule, our memories romanticize the past. But when one has renounced a creed or been betrayed by a friend, the opposite mechanism sets to work. In the light of that later knowledge, the original experience loses its innocence, becomes tainted and rancid in recollection. I have tried in these pages to recapture the mood in which the experiences [in the Communist Party] related were originally lived and I know that I have failed. Irony, anger, and shame kept intruding; the passions of that time seem transformed into perversions, its inner certitude into the closed universe of the drug addict; the shadow of barbed wire lies across the condemned playground of memory. Those who were caught by the great illusion of our time, and have lived through its moral and intellectual debauch, either give themselves up to a new addition of the opposite type, or are condemned to pay with a lifelong hangover.

This need not be true of all ex-communists. Some may still feel that their experience has been free from the morbid overtones described by Koestler. Nevertheless, Koestler has given here a truthful and honest characterization of the type of ex-communist to which he himself belongs. But it is difficult to square this self-portrait with his other claim that the confraternity for which he speaks 'are the only people ... who know what it's all about'. With equal right a sufferer from traumatic shock might claim that he is the only one who really understads wounds and surgery. The most that the intellectual ex-communist knows, or rather feels, is his own sickness; but he is ignorant of the nature of the external violence that has produced it, let alone the cure.

This irrational emotionalism dominates the evolution of many an ex-communist. 'The logic of opposition at all cost,' says Silone, 'has carried many ex-communists far from their starting points, in some cases as far as fascism.' What were those starting-points, in some cases as far as fascism.' What were those starting-points? Nearly every ex-communist broke with his party in the name of communism. Nearly every one set out to defend the ideal of socialism from the abuses of bureaucracy subservient to Moscow. Nearly every one began by throwing out the dirty water of the Russian Revolution to protect the baby bathing in it.

Sooner or later these intentions are forgotten or abandoned. Having broken with a party bureaucracy in the name of communism, the heretic goes on to break with communism itself. He claims to have made the discovery that the root of the evil goes far deeper than he at first imagined, even though his digging for that 'root' may have been very lazy and very shallow. He now defends mankind from the fallacy of socialism. He no longer throws out the dirty water of the Russian Revolution to protect the baby; he discovers that the baby is a monster which must be strangled. The heretic becomes a renegade.

How far he departed from his starting-point, whether, as Silone says, he becomes a fascist or not, depends on his inclinations and tastes – and stupid stalinist heresy-hunting often drives the ex-communist to extremes. But whatever the shades of individual attitudes, as a rule the intellectual ex-communist ceases to oppose capitalism. Often he rallies to its defence, and he brings to this job the lack of scruple, the narrow-mindedness, the disregard for truth, and the intense hatred with which stalinism has imbued him. He remains a sectarian. He is an inverted stalinist. He continues to see the world in white and black, but now the colours are differently distributed. As a communist he saw no difference between fascists and social democrats. As an anti-communist he sees no difference between nazism and communism. Once, he accepted the party's claim to infallibility; now he believes himself to be infallible. Having once been caught by the 'greatest illusion', he is now obsessed by the

greatest disillusionment of our time.

His former illusion at least implied a positive ideal. His disillusionment is utterly negative. His role is therefore intellectually and politically barren. In this, too, he resembles the embittered ex-jacobin of the Napoleonic era. Wordsworth and Coleridge were fatally obsessed with the 'Jacobin danger'; their fear dimmed even their poetic genius. It was Coleridge who denounced in the House of Commons a bill for the prevention of cruelty to animals as the 'strongest instance of legislative jacobinism'. The ex-jacobin became the prompter of the anti-jacobin reaction in England. Directly or indirectly, his influence was behind the Bills Against Seditious Writings and Traitorous Correspondence, the Treasonable Practices Bill, the Seditious Meetings. Bill (1792-4), the defeats of parliamentary reform, the suspension of the Habeas Corpus Act, and the postponement of the emancipation of England's religious minorities for the lifetime of a generation. Since the conflict with revolutionary France was 'not a time to make hazardous experiments', the slave trade, too, obtained a lease on life – in the name of liberty.

In quite the same way our ex-communist, for the best of reasons, does the most vicious things. He advances bravely in the front rank of every witch hunt. His blind hatred of his former ideal is leaven to contemporary conservatism. Not rarely he denounces even the mildest brand of the 'welfare state' as 'legislative bolshevism'. He contributes heavily to the moral climate in which a modern counterpart to the English anti-jacobin reaction is hatched. His grotesque performance reflects the impasse in which he finds himself. The impasse is not merely his – it is part of a blind alley in which an entire generation leads an incoherent and absent-minded life.

The historical parallel drawn here extends to the wider back-ground of two epochs. The world is split between stalinism and an anti-stalinist alliance, in much the same way as it was split between Napoleonic France and the Holy Alliance. It is a split between a 'degenerated' revolution exploited by a despot and a grouping of predominantly although not exclusively conservative interests. In terms of practical politics the choice seems to be now, as it was then, confined to these alternatives. Yet the rights and the wrongs of this controversy are so hopelessly confused that whichever the choice, and whatever its practical motives, it is almost certain to be wrong in the long run and in the broadest historical sense.

An honest and critically minded man could reconcile himself to Napoleon as little as he can now to Stalin. But despite Napoleon's violence and frauds, the message of the French Revolution survived, to echo powerfully throughout the nineteenth century. The Holy Alliance freed Europe from Napoleon's oppression; and for a moment its victory was hailed by most Europeans. Yet what Castlereagh and Metternich and Alexander I had to offer to 'liberated' Europe was merely the preservation of an old decomposing order. Thus the abuses and the aggressiveness of an empire bred by the Revolution gave a new lease on life to European feudalism. This was the ex-Jacobin's most unexpected triumph. But the price he paid for it was that presently he himself, and his anti-Jacobin cause, looked like vicious ridiculous anachronisms. In the year of Napoleon's defeat, Shelley wrote to Wordsworth :

> In honoured poverty the voice did weave
> Songs consecrate to truth and liberty –
> Deserting these, thou leavest me to grieve,
> Thus having been, that thou shouldst cease to be.

If our ex-communist had any historical sense, he would ponder this lesson. ...

'Far, far more abject is thy enemy' might have been the text for *The God That Failed*, and for the philosophy of the lesser evil expounded in its pages. The ardour with which the writers of this book defend the West against Russia and communism is sometimes chilled by uncertainty or residual ideological inhibition. The uncertainty appears between the lines of their confessions, or in curious asides.

Silone, for instance, still describes the pre-Mussolini Italy, against which as a communist he had rebelled, as 'pseudodemocratic'. He hardly believes that post-Mussolini Italy is any better, but he sees its stalinist enemy to be 'far, far more abject'. More than the other co-authors of this book, Silone is surely aware of the price that Europeans of his generation have already paid for the acceptance of lesser-evil philosophies. Louis Fischer advocates the 'double rejection' of communism and capitalism, but his rejection of the latter sounds like a feeble face-saving formula; and his newly found cult of Gandhi-ism impresses one as merely an awkward escapism. But it is Koestler who occasionally, in the midst of all his affectation and anti-communist frenzy, preveals a few curious mental reservations. '... If we survey history (he says) and compare the lofty aims in the name of which revolutions were started, and the sorry end to which they came, we see again and again how a *polluted civilization polluties its own revolutionary offspring*'. (My italics) ... If the 'revolutionary offspring', communism, has really been 'polluted' by the civilization against which it has rebelled, then no matter how repulsive the offspring may be, the source of the evil is not in it but in that civilization. And this will be so regardless of how zealously Koestler himself may act as the advocate of the 'defenders' of civilization *a la* Whitaker Chambers.

Even more startling is another thought ... with which Koestler unexpectedly ends his confession.

I served the Communist Party for seven years – the same length of time as Jacob tended Laban's sheep to win Rachel his daughter. When the time was up, the bride was led into his dark tent; only the next morning did he discover that his ardours had been spent not on the lovely Rachel but on the ugly Leah. I wonder whether he ever recovered from the shock of having slept with an illusion. I wonder whether afterwards he believed that he had ever believed in it. I wonder whether the happy end of the legend will be repeated; for at the price of another seven years of labour, Jacob was given Rachel too, and the illusion became flesh. And the seven years seemed unto him but a few days, for the love he had for her.

One might think that Jacob-Koestler reflects uneasily whether he has not too hastily ceased tending Laban – Stalin's sheep, instead of waiting patiently till his 'illusion became flesh'.

The words were not meant to blame, let alone to castigate, anybody. Their purpose, let this be repeated, is to throw into relief a confusion of ideas from which the ex-communist intellectual is not the only sufferer.

In one of his recent articles, Koestler vented his irritation at those good old liberals who were shocked by the excess of anti–communist zeal in the former communist, and viewed him with the disgust with which ordinary people look at 'a defrocked priest taking out a girl to a dance'.

Well, the good old liberals may be right, after all : this peculiar type of anti-communist may appear to them like a defrocked priest 'taking out' not just a girl but a harlot. The ex-communist's utter confusion of intellect and emotion makes him illsuited for any political

activity. He is haunted by a vague sense that he has betrayed either his former ideals or the ideals of bourgeois society; like Koestler, he may even an ambivalent notion that he has betrayed both. He then tries to suppress his sense of guilt and uncertainty, or to camouflage it by a show of extraordinary certitude and frantic aggressiveness. He insists that the world should recognize his uneasy conscience with any cause except one – self-justification. And this is the most dangerous motive for any political activity.

It seems that the only dignified attitude the intellectual ex-communist can take is to rise *au-dessus de la mēlée*. He cannot join the stalinist camp or the anti-stalinist Holy Alliance without doing violence to his better self. So let him stay outside any camp. Let him try to regain critical sense and intellectual detachment. Let him overcome the cheap ambition to have a finger in the political pie. Let him be at peace with his own self at least, if the price he has to pay for phony peace with the world is self-renunciation and self-denunciation. This is not to say that the ex-communist man of letters, or intellectual at large, should retire into the ivory tower. (His contempt for the ivory tower lingers in him from his past.) But he may withdraw into a watch-tower instead. To watch with detachment and altertness this heaving chaos of a world, to be on a sharp lookout for what is going to emerge from it, and to interpret it *sine ira et studio* – this is now the only honourable service the ex-communist intellectual can render to a generation in which scrupulous observation and honest interpretation have become so sadly rare. (Is it not striking how little observation and interpretation, and how much philosophizing and sermonizing, one finds in the books of the gifted pleiad of ex-communist writers?)

But can the intellectual really now be a detached observer of this world? Even if taking sides makes him identify himself with causes that in truth are not his, must he not take sides all the same? Well, we can recall some great 'intellectuals' who in a similar situation in the past refused to identify themselves with any established cause. Their attitude seemed incomprehensible to many of their contemporaries : but history has proved their judgement to have been superior to the phobias and hatreds of their age. Three names may be mentioned here: Jefferson, Goethe, and Shelley. All three, each in a different way, were confronted with the choice between the Napoleonic idea and the Holy Alliance. All three, again each in a different manner, refused to choose.

Jefferson was the staunchest friend of the French Revolution in its early heroic period. He was willing to forgive even the Terror, but he turned away in disgust from Napoleon's 'military despotism'. Yet he had no truck with Bonaparte's enemies, Europe's 'hypocritical deliverers', as he called them. His detachment was not merely suited to the diplomatic interest of a young and neutral republic; it resulted naturallly from his republican conviction and democratic passion.

Unlike Jefferson, Goethe lived right inside the storm centre. Napoleon's troops and Alexander's soldiers, in turn, took up quarters in his Weimar. As the Minister of his Prince, Goethe opportunistically bowed to every invader. But as a thinker and man, he remained non-committal and aloof. He was aware of the grandeur of the French Revolution and was shocked by its horrors. He greeted the sound of French guns at Valmy as the opening of a new and better epoch, and he saw through Napoleon's follies. He acclaimed the liberation of Germany from Napoleon, and he was acutely aware of the misery of that 'liberation'. His aloofness, in these as in other matters, gained him the reputation of 'the Olympian'; and the label was not always meant to be flattering. But his Olympian appearance was due least of all to an inner indiffer-

ence to the fate of his contemporaries. It veiled his drama; his incapacity and reluctance to identify himself with causes, each an inextricable tangle of right and wrong.

Finally, Shelley watched the clash of the two worlds with all the burning passion, anger, and hope of which his great young soul was capable : he surely was no Olympian. Yet not for a single moment did he accept the self-righteous claims and pretensions of any of the belligerents. Unlike the ex-jacobins, who were older than he, he was true to the Jacobin republican idea. It was as a republican, and not as a patriot of the England of George III, that he greeted the fall of Napoleon, that 'most unambitious slave' who did 'dance and revel on the grave of Liberty'. But as a republican he know also that 'virtue owns a more eternal foe' than Bonapartist force and fraud – 'Old Custom, legal Crime, and bloody Faith' embodied in the Holy Alliance.

All three – Jefferson, Goethe, and Shelley – were in a sense outsiders to the great conflict of their time, and because of this they interpreted their time with more truthfulness and penetration than did the fearful, the hate-ridden partisans on either side.

What a pity and what a shame it is that most ex-communist intellectuals are inclined to follow the tradition of Wordsworth and Coleridge rather than that of Goethe and Shelley.

PAS

Ram Sharan Sharma (1919-2011)

Subhendu Sarkar

Born in a poor family of Begusarai, Bihar, Ram Sharan Sharma, one of the most influential historians of India, had to support himself initially by the earnings from scholarships and private tuitions. Passing matriculation in 1937 Sharma entered Patna College at the intermediate level and went on to get the M.A. degree. After teaching for a couple of years at Ara and Bhagalpur he joined Patna College, Patna University in 1946. Later Sharma became Professor and Dean of the History Department at Delhi University where he served from 1973 to 1978. He obtained his Ph. D. from the School of Oriental and African Studies, University of London working under the supervision of A.L. Basham. Recipient of many awards, Ram Sharan Sharma was the visiting Professor of History in the University of Toronto (1955-66), visiting fellow at the School of Oriental and African Studies, University of London (1959-64), founding Chairperson of Indian Council of Historical Research (1972-77), Deputy Chairperson of UNESCO's International Association for Study of Central Asia (1973-78) and an important member of the National Commission of History of Sciences in India and a member of the University Grants Commission. In 2002 the Indian History Congress conferred on him the Vishyanath Kashinath Rajwade Award by for his service and contribution to Indian history. Sharma had written numerous books which have been translated in all the major Indian and foreign languages.

Coming in contact with the peasant leaders like Karyanand Sharma and Sahajanand Saraswati and scholars like Rahul Sankrityayan in his youth, Ram Sharan Sharma developed

a determination to fight for social justice which eventually drew him towards leftist ideology. His later association with Sachchidanand Sinha, a social reformer and journalist, broadened his mental horizon, making him one of the major anti-imperialist and anti-communal intellectuals of India. Applying the tenets of Marxism, Sharma managed to bring the peasants into the study of Indian history. Limiting himself mainly to the study of ancient and medieval India, Sharma, following in the footsteps of D.D. Kosambi, focussed his attention on the lower orders, examining their relationship with the means of production. With the publication of *Sudras in Ancient India* in 1958 he began a life-long study of the various aspects of the class-divided society. His study of the origin and growth of feudalism in early India with the means of an overwhelming mass of literary and archaelogical sources are to be found in like *Indian Feudalism* (1965), *Social Changes in Early Medieval India (c.AD 500-1200) (1969), Urban Decay in India (c. 300-1000) (1987) and Early Medieval Indian Society : A Study in Feudalisation* (2001). Sharma applied the tool of historical materialism not only to explain social differentiation and stages of economic development but also realm of ideology. His investigations into the 'feudal mind' and 'economic and social basis of tantrism' opened up a whole new area of inquiry.

As a Marxist Ram Sharan Sharma found it necessary to fight against the communalist historians who present a distorted view of Indian history. He demolished the myth that the Aryans were the original inhabitants of Indian in *Looking for the Aryans* (1995) and *Advent of the Aryans in India* (1999). Besides, by asserting that the Ram Setu was a result of a continuous wave action he successfully diffused the crisis which emerged due to the claim made by the fundamentalist forces. In *Communal History and Rama's Ayodhya* (1999) Sharma stated – using primary sources like Tulsidas's *Ramcharitmanas* (1574) – that Ayodhya was never a place of Hindu pilgrimage. After the demolition of Babri Masjid, Sharma, together with historians like Swaraj Bhan, M.Athar Ali and D.N. Jha, came up with the *Historian's report to the nation* expressing the view that the communalists were mistaken in their assumption that there was a temple at the disputed site. He had unequivocally condemned the sheer vandalism in bringing down the mosque. Moreover, he also denounced the vandalism of Bhandarkar Oriental Research Institute in 2004.

A man known for his simplicity who had, at the same time, enough courage to fight for his convictions, Ram Sharan Sharma has been a continous source of inspiration not only for his students and friends but also for his readers. He is a glorious example of an indefatigable intellectual who combined social commitment with academic pursuits. PAS

Birth Centenary

Dr. Dhirendranath Gangopadhyay Memorial Lecture

(1911–2011)

Speaker : Mr. Shamik Bandyopadhyay
Venue : Bangla Academy Conference Hall
Date & Time : 23.12.2011, at 5 P.M.
Subject : Psycho-sociological aspects of Dhirendranath's Drama.

Arsenic bioaccumulation in edible plants and subsequent transmission through food chain in Bengal basin: With special reference to rice

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1. Introduction:

Arsenic is a metalloid (atomic no. 33) of great environmental concern due to its extravagant toxicity and colossal abundance (Nordstrom, 2002). Arsenic is a potent endocrine disruptor and can alter hormone mediated cell signaling processes in living organisms at extremely low concentration (Kaltreider et al., 2001). It is tasteless, colourless, odourless and its detection in water and biological samples need expensive and sophisticated techniques that are only accessible to selected research laboratories and universities. It ranks 20th in abundance in the earth's crust, 14th in the seawater and 12th in the human body (Mondal and Suzuki, 2002). Arsenic naturally occurs in over 200 different mineral forms, of which around 60% are arsenates, 20% are sulfides and sulfosalts and the rest 20% are arsenides, arsenites, oxides, silicates and elemental arsenic (Bissen and Frimmel, 2003). The source of arsenic is mainly geological, but anthropological activities like mining, burning of fossil fuels and uses of pesticides also cause arsenic contamination (WHO, 2001).

Arsenic contamination in groundwater has been reported in Bangladesh, India, China, Taiwan, Vietnam, USA, Argentina, Chile and Mexico. In many of these places the concentration has exceeded the permissible limit of 50 ppb recommended by WHO (WHO, 2001).

The Bengal basin is regarded to be the most acutely arsenic affected geological province in the world (Mukherjee et al., 2008). The Bengal arsenic disaster is possibly the worst environmental disaster in the history of human civilization, and much more serious than Bhopal Gas Tragedy or Chernobyl Nuclear disaster. The Bengal basin was formed by the sedimentation of the river Ganga, Brahmaputra and Meghna, along with their tributaries and distributaries (Mukherjee et al., 2008). The densely populated areas of Bangladesh and India, although traversed by two of the world's largest river systems and recipient of several meters of rainfall yearly, faces unparalleled water-supply problems (Roychowdhury et al., 2008). More than 100 million people are living in the arsenic affected districts of India and Bangladesh. 9 districts out of 19 in West Bengal, 78 blocks and around 3150 villages are affected with arsenic-contaminated groundwater (Chakraborti et al., 2002). Groundwater is regularly used for agricultural and household purposes in these areas. As rainwater is insufficient to support the water demand of the increasing population and intensive agricultural system of West Bengal, thousands of shallow tube-wells were installed for irrigation in last 40-45 years (Roychowdhury et al., 2008). A vast majority of these tube wells have been installed privately with locally

available expertise, without any check of the quality and yield of the water that originates from them. Heavy withdrawal of groundwater, especially during that lean period, resulted in oxygenated decomposition of pyrites forming Fe2+ and Fe3+ sulphates and sulphuric acid, which in turn are responsible for arsenic mobilization (Bhattacharya et al., 2007). The use of arsenic contaminated groundwater for irrigation purpose in crop fields elevates arsenic concentration in surface soil and in the plants grown in those areas (Meharg et al., 2003). Many millions of cubic meters of underground water are used for agricultural irrigation. Much of this groundwater is contaminated with arsenic, which is deposited in the soil in contact with the irrigation water throughout the year. In Bangladesh and West Bengal most of the arsenic added from contaminated irrigation water in rice cultivation remains on the surface soil (Norra et al., 2005). The reason behind it is the soil used for paddy cultivation is deliberately puddled to hold water on the surface and they develop a compacted, impervious ploughpan (Brammer, 1996).

Soil arsenic levels are very much related with local well water arsenic concentration, which indicate that the source of soil contamination is the irrigation water (Bhattacharya et al., 2007). The absorption of arsenic by plants is influenced by the concentration of arsenic in the soil. In Bangladesh, where irrigation is carried out with arsenic contaminated groundwater, soil arsenic level can reach up to 83 mg/kg (Roychowdhury et al., 2005). Except in the rainy season, the agricultural land has been exposed to irrigated groundwater round the year. Sometimes the farmers used to run the shallow tube wells in the rainy season due to insufficient rain. Most of the vegetables and other crops, used by the villagers were cultivated in this area and entered the local market.

2. Mechanisms of arsenic toxicity in plants:

The arsenic concentrations in the edible parts of a plant depend on the availability of the soil arsenic and the accumulation and translocation ability of a plant (Huang et al., 2006). Several plant species such as ferns have been studied for their ability to accumulate arsenic. The Chinese brake fern (Pteris vittata) was reported as the hyper accumulator of arsenic and can remove arsenic from soil (Ma et al., 2001). Arsenic (V) is also reduced by other plant species such as Indian mustard (Brassica juncea) and Arabidopsis thaliana (Tripathi et al., 2007). However, these species have a lower arsenic accumulation capacity compared to P.vittata. High amount of arsenic can be accumulated in vegetables including arum, Kachu sak (Colocasia antiquorum) and Ipo-mea (kalmi) (Das et al., 2004). Other plants like maize, barley and ryegrass, Spertina alterniflora can also accumulate arsenic efficiently into their bodies (Sadiq, 1986; Jiang and Singh, 1994; Carbonell et al., 1998). Plants rarely accumulate arsenic at concentrations that can create health hazards, because phytotoxicity usually occurs before reaching such concentrations (Walsh and Keeney, 1975). Food composites (potato skin, leaves of vegetables, rice, wheat, cumin, turmeric powder, and cereals) collected from arsenic affected sites of the Murshidabad district of West Bengal contained 7-373 ¦g kg-1 (Roychowdhury et al., 2002). It has also been observed that arsenic can accumulate in the rice grains upto 7.5 mg/kg even when the source of contamination is 2 km. away (Roychowdhury et al., 2002). However, to assess the risk posed by arsenic in the diet, speciation of arsenic must be ascertained in those contaminated food sources, since inorganic arsenic (arsenate and arsenite) is more toxic than methylated organic (monomethyl arsonic acid, MMAV; dimethyl arsinic acid, DMAV) forms found in plants (Meharg and Hartley, 2002; Abedin et al., 2002).

Besides the anthropogenic sources of arsenic species such as sodium arsenate or sodium salts of methylarsonate acid (weed killer), calcium arsenate (herbicide), lead arsenate (insecticide), etc, methylated arsenic species are formed in soils by biomethylation processes. The inorganic and methylated forms can reach the rice grains though an absorption mechanism (Pizarro et al., 2003).

In general, plants uptake and metabolize As(V) through the phosphate transport channels (Tripathi et al., 2007). Because of their chemical similarity, arsenic competes with phosphate for root uptake and interferes with metabolic process like ATP synthesis and oxidative phosphorylation (Tripathi et al., 2007). Arsenate is taken up by phosphate transporter in plants grown on aerobic soils. The presence of phosphate has a negative effect on the bioaccumulation of pentavalant arsenic in plants (Liu et al., 2004). If arsenate has lower concentration than phosphate level in soil, phosphate is a much better competitor for uptake than arsenate (Meharg et al., 1994). In contrast, arsenite is the predominant species of arsenic in soil under anaerobic conditions (Masscheleyn et al., 1991). Recent studies have shown that in rice plants, arsenite is taken up at high rates of influx which follows the Michaelis-Menten kinetics (Abedin et al., 2002). In rice, arsenic uptake shares the same pathway as silicon uptake. Rice is a strong accumulator of silicon which may allow efficient uptake and translocation of arsenite in the shoots (Hodson et al., 2005). The aquaporin Lsi1 (protein) which is responsible for the influx of silicon (as silicic acid) into the root cells, is permeable to arsenite (Ma et al., 2008). The reason behind it is the similarity between the size and coordination chemistry of silicic acid and arsenite. Inside plant tissues, arsenic is reduced from pentavalant to trivalent state or is biotransformed to less toxic organic compounds such as DMA, MMA (Ma et al., 2008). Trivalent arsenic can form complex with thiol groups inside the plant tissues (Zhao et al., 2010). Many plants can synthesize an enzyme called arsenic reductase, which can convert the pentavalant arsenic into trivalent form (Zhao et al., 2010). Interestingly, trivalent arsenic is the predominant species plant tissues and 50-65% of the total arsenic accumulated in stem or leaf parts is trivalent (Peralta-Videa et al., 2009). The arsenic detoxification in plants involves arsenic mobilization from roots to aerial parts of the plant (translocation). This movement is controlled by the external arsenic concentration (Zhao et al., 2010). Plants generally have a low efficiency of arsenic translocation from roots to shoots, may be due to the formation of complexes of arsenite and thiol compounds and subsequent sequestration in the root vacuoles, or because of the strong efflux of arsenite to the external medium (Zhao et al., 2009).

Toxicity limit and mobility of arsenic in soil depend on the properties of soil like particle size, texture, mineral nutrient content, pH, presence of other ions, moisture regimes, transformations by microbes and the chemical form of arsenic (Bhattacharya et al., 2007). Arsenic is more mobile and bio-available in sandy soil than in clayey soil. The effect of arsenic toxicity in plants increase in low pH, but the uptake mechanism can enhance in higher pH soil. These properties of soil are very much relevant to evaluate the influence of arsenic on its accumulation and distribution in plants. Arsenic accumulation in soil irrigated by arsenic contaminated water and its transfer into rice may vary depending on the soil types, cropping pattern, arsenic concentration in irrigation water, distance from the water source, depth of water source and duration of the monsoon flood (Hossain et al., 2008). The typical transfer factor for arsenic varied from 0.01 to 0.1 (Kloke et al., 1984). The volume of water used for the irrigation of a

specific crop varies considerably depending not only on climatic factors, but also on the permeability of soil. The water demand of rice is particularly high; the volume of water used for irrigation of Boro rice in the Indo-Gangetic Plain are in the range between 1000 and 1800 mm/a (Gupta et al., 2002; Huq et al., 2003).

In seasonally flooded soil, soil change between the oxidized state in the dry season and the reduced state in the wet season when the soil is submerged .So arsenic may present in the soil in different form and in different concentration in different times of the year. However, flooding leads to fundamental changes in the soil. The overlying floodwater inhibits oxygen movement into the soil and the remaining oxygen is depleted within a short time (Bhattacharya et al., 2007). Rice plants are generally grown in submerged soil condition, where arsenic bioavailability is generally high (Bhattacharya et al., 2007). Rice roots can constitutively form aerenchyma and waterlogging or O2-deficient conditions can enhance the process (Evan, 2003; Colmer, 2003a; Colmer 2003b; Colmer et al., 2006). In roots, O2 is essential for respiration to provide sufficient energy for growth, maintenance, and nutrient uptake processes, and up to 30-40% of the O2 supplied via the root aerenchyma is being lost to the soil by the process of radial oxygen loss (Colmer, 2003a; Colmer 2003b). Formation of aerenchyma and radical oxygen loss can enhance the waterlogging tolerance mechanisms of rice plants (Colmer, 2003a; Colmer 2003b). There is a significant correlation between radical oxygen loss and arsenic tolerance and accumulation in rice plants (Mei et al., 2009).

It is known that rice maintains relatively high redox potentials in the rhizosphere, by a continuous flux of O2 from the shoots toward the roots. The release of O2 enables the accumulation of Fe-oxyhydroxides (typically lepidocrocite, goethite, ferrihydrite) in the rhizosphere of living plants (Norra et al., 2005). Consequently, facultative and obligate anaerobes use oxidized forms in soil for respiration, e.g., iron-(hydr)oxide is reduced to Fe2+ and simultaneously As dissolves into soil solution (Inskeep et al., 2002). Further, rice plant can carry oxygen from the air through stems and can distribute it into the root zone. So, the oxidized zone created around the root area helps to form oxidized iron plaque. Iron plaque can efficiently bind arsenic and can reduce its translocation to the above ground tissues (straw, husk and grain) of the plant. It has also been reported that the accumulation of arsenic in rice plants is highest in the root zones and decease significantly in the upper parts of the plant (Bhattacharya et al., 2007). Arsenate has a high affinity for iron plaque and can react with Fe (III) to give the highly insoluble iron arsenate. The concentration of arsenic in rice roots can reach as high as 160 mg/kg due to the formation of iron plaques. So, iron plaque can affect arsenic dynamics significantly in the rhizosphere zones (Norra et al., 2005). Arsenate behaves as a phosphate analogue, and like phosphate is relatively immobile in soil (Liu et al., 2004). Arsenic phytotoxicity is generally greater in sandy soils than that of clayey soils as sandy soils contain comparatively low amounts of iron oxides and clays (Sheppard, 1992).

3. Arsenic contamination in rice:

Globally, over 400 million metric tons of milled rice is consumed each year, which accounts for around 50% of total cereal consumption of the world (IRRI, 2007). Rice is the main crop in West Bengal and 73% of the calorific intake of the people is from rice. Huge amount of water is needed for rice cultivation. Rice is generally grown in submerged flooded condition, where arsenic bioavailability is high in soil (Duxbury and Panaullah, 2007). Rice is much more

efficient at assimilating arsenic into its grain than other staple cereal crops (Williams et al., 2007). Arsenic accumulation in soil irrigated by arsenic contaminated water and its transfer into rice may vary depending on the soil types, cropping pattern, arsenic concentration in irrigation water, distance from the water source, depth of water source and duration of the monsoon flood (Hossain et al., 2008). As(???) and MMA (Monomethyl arsenic acid) are phytotoxic to rice plants and the degree of arsenic uptake in rice followed as As(???)>MMA>As(V)>DMA (Meharg and Rahman, 2003). The root, shoot and leaf tissue of rice plant contain mainly inorganic As (III) and As (V) while the rice grain contain predominantly DMA (85 to 94%) and As (III) (Liu et al., 2005).

Drinking water is responsible for 13% of total arsenic intake where cooked rice can contribute up to 56% of total intake which indicates rice can contribute most of the daily arsenic intake (Ohno et al., 2007). Rice can contribute 51-60% of the dietary intake of arsenic in Bangladesh if rice grains contain 0.5-0.7 mg/kg of arsenic and drinking water contains 100 ppb of arsenic in average (considering 2 litre/day water consumption by each person) (Meharg and Rahman, 2003). According to a study, rice grain can contribute about 95% of arsenic, with respect to the dietary intakes of arsenic from the food samples (Roychowdhury, 2008). Infants and young people generally have higher exposure to arsenic through rice on a body mass basis, when compared to the adults (Meharg et al., 2008). The median increased lifetime cancer risk from drinking water, rice and cooking of rice was found to be 48%, 44% and 8% respectively (Mondal and Polya, 2008). It has been reported that the concentration of arsenic in cooked rice was higher than that of raw rice. The concentration of arsenic in rice is increased when it was cooked with arsenic contaminated groundwater and the gruel was not discarded after cooking. The arsenic was absorbed in the cooked rice from water, thus increased the concentration (Roychowdhury, 2008).

Arsenic concentration in boro rice is much higher than in aman variety, because much higher amount of water is needed for boro cultivation compared to aman cultivation (Williams et al., 2006). Some researchers found a much higher transfer factor of arsenic from soil to the shoots of rice plants compared to wheat and barley (Su et al., 2010). Additionally, unpolished rice has been reported to contain higher arsenic concentrations compared to polished rice samples because the milling and polishing process significantly reduces arsenic concentration in rice grains. Arsenic also highly accumulates in the grain surface, which is one of the main causes of such difference. Modern health conscious people generally prefer whole grain diet, which, in turn can increase the toxicity level in human body if the grains are contaminated with arsenic.

Rice bran is a byproduct of polishing whole grain rice. Stabilized rice bran extract, which is also known as bran soluble, is sold as a “natural superfood” and “premier heath food product”, because of its high food value. A number of companies supply this product to malnourished children as daily ration in many countries. The supplement has already been used in Malawi, Guatemala, and El Salvador, with plans to expand further into Latin America, India, and the Caribbean. Proper risk assessment has not been done yet on this product, which can be a source of arsenic contamination (Sun et al., 2008). A wide range of other rice products are used as baby foods such as cereal dusts, noodles, biscuits- all of which can be significant sources of arsenic contamination in infants and babies (Mennella et al., 2006).

Apart from rice, arsenic has been found in some vegetables also including data sak and lal

sak, kalmi (Bengali name), Indian mustard, maize, barley etc. (Huq et al., 2006).

4. Indirect effects of arsenic bioaccumulation in rice:

The accumulation of arsenic in plants occurs primarily through the root systems and the highest arsenic concentrations have been reported in plant roots and tubers. The edible parts of the tuber crops are exposed continuously to soil and irrigation water contaminated with arsenic, which, in turn, can increase arsenic level in the tuber part (Rahman et al., 2008). Rice straw is often used as a cattle feed in South Asia. This represents another entry route of arsenic into the food chain, as rice straw typically contains much higher amount of arsenic than grains .Cattle population also used to drink water contaminated with arsenic in those areas, which, in turn, can further increase the toxicity level. But the toxicity mechanism is highly dependent on the nature of arsenic species in the straw and on the metabolism of the cattle (Abedin et al., 2002). Cattle manure is often used as fuel in household purposes, which can also increase the contamination risk (Pal et al., 2007). Besides, the dry straw often been used by people as fuel, which can release arsenic in air as oxides, and can cause pollution and health hazards.

5. Economic hazards of arsenic bioaccumulation in rice:

As arsenic species are very much toxic to plants, they can affect the overall production of rice and other vegetables, and can affect the economy of a country as whole. Arsenic toxicity can reduce the rate of photosynthesis in rice plants, which, in turn can reduce the chlorophyll content, and can affect the growth and yield of rice (Rahman et al., 2007). Rice yield has been reported to decrease by 10% when the concentration of arsenic in soil is as high as 25 mg/kg (Xiong et al., 1987). It has been shown that in T-Aman rice (Oryza sativa L.), the grain and straw yields were significantly reduced by the artificial introduction of arsenic in soil (Azad et al., 2009). Experiments proved that arsenic in the growth medium of rice seedlings caused quantitative changes in the level of RNA, soluble proteins, free amino acids and proline and inhibits the activities of RNase and protease. Further, arsenite toxicity can lead to change in isoform pattern of RNase in growing rice seedlings. The impact of such responses could be visible in the form of decreased growth and vigour of rice seedlings in arsenic-polluted environments (Mishra and Dubey, 2006).

Decrease in rice productivity in response to arsenic toxicity can affect the economy of a country. The major portion of the population at risk of arsenic poisoning also suffer from malnutrition, and there is a direct link between malnutrition and the risk of arsenic poisoning in human body (Milton et al., 2010). The long term effects are slowly executed by more cancers, stillbirths, defective childbirths, hypertension and lots of other diseases (Milton et al., 2010). Several studies showed that arsenic accumulation significantly affects body weight, biological and intellectual development in children (Majumder et al., 2010). This, in turn, can affect the social and economic structure of a family as a whole. Rural populations generally eat locally-grown rice in arsenic affected areas and the chances of arsenic toxicity are much more than the urban populations. In urban areas, middle class and rich people usually eat wheat, vegetables and potatoes from mixed or diverse sources, which contain lesser amount of arsenic in general. Difference in locations and economic classes should be examined properly in dietary studies to identify the problem in details.

6. Mitigation policies:

When arsenic is accumulated in the rice grains, it is very difficult to remove it properly. Cooking with high volume of arsenic free water can help to some extent, but, it can also remove beneficial vitamins and thus can decrease the food value. Levels of toxicity also depend on the cooking methods which vary in different regions. For example, in Hungary, rice is generally cooked with an excessive amount of water and the water remaining is discarded; on the other hand, in China, rice is generally cooked with aliquots of water in order to absorb it all (Mihucz et al., 2007).

Aerobic cultivation of rice can decrease arsenic bioaccumulation significantly, as in anaerobic submerged field conditions, the chances of arsenic bioavailability is high (Xu et al., 2008). Rainwater can be an effective source which can be used in irrigation in large scale, through proper water management systems, which, in turn can reduce the use of arsenic contaminated water in irrigation in respective contaminated zones. Rainwater can also reduce the concentration of arsenic in surface soil, which, in turn, can reduce the accumulation of arsenic in rice and other edible plants. The annual average rainfall in India is 4000 billion cubic meters, but the annual water requirement of India is only 450 billion cubic meters (Rao, 1995). It clearly indicates that the main problem of Indian water resources is mismanagement and unsustainable use of water, which, in turn, is making the whole situation paradoxical. Proper management of rainwater can reduce the groundwater consumption in agricultural sectors. In West Bengal and Bangladesh, the surface water bodies like rivers, wetlands, flooded river basins and oxbow lakes are among the largest in the world (Roychowdhury et al., 2005). Due to our negligence most of these water bodies is now contaminated with waste materials and pollutants. If we can use these resources properly for drinking, cooking, agricultural irrigation and other purposes, then we can save the possible arsenic contamination from groundwater. Pisciculture, duckery, vegetable cultivation at the bank of these water bodies can also improve the economic condition of the local people. Proper watershed management and villager participation are needed to assist in the utilization of these huge bodies of water. Where soils are contaminated with arsenic and an alternative safe irrigation supply cannot easily be provided, farmers should be encouraged to increase crop production under rainfed conditions where this is practical. Another management system can be done by providing the affected population with proper protein diet and protein supplements which can create a shield against arsenic poisoning (Maity and Chatterjee, 2000).

Phytoremediation is an emerging sustainable technology which can be successfully used to remove heavy metals like arsenic from the contaminated soil, sediments, groundwater and surface water (Alkorta and Garbisu, 2001). The plants which can accumulate arsenic in their bodies should be identified properly which can be used in a large scale to remove arsenic from soil effectively. Recently, researchers from the University of Georgia have established a new technique by introducing genetically modified plants which can tolerate arsenic and have the capacity to remove arsenic from contaminated sites (Dhankher et al., 2002). As some specific plants like the Chinese brake fern have the capacity to accumulate arsenic, there is a possibility of existence of some genes which are responsible for the detoxification mechanism (Tongbin et al., 2002). Further research can be done for the isolation of these genes, which can be used effectively in arsenic bioremediation process. Genetic variation is an important factor for controlling arsenic uptake, speciation and reaction to arsenic stress (Tripathi et al.,

2007). The accumulation of arsenic in rice plants varied with different variety of rice (Norton et al., 2009). For example, arsenic speciation analysis showed that brown rice can accumulate higher amount of inorganic arsenic than white rice (Meharg et al., 2008). Experiments showed that Indian basmati rice varieties has 5-fold lower total arsenic content, and 2.75-fold lower inorganic arsenic content than the US rice varieties (Williams et al., 2005).

Arsenic resistant genotypes of rice varieties should be considered to reduce the accumulation rate, which, in turn, can solve the problem partly. Some genotypes which can accumulate lesser amount of arsenic, specially the trivalent toxic form, can be used in breeding programmes and genetic researches for identifying the beneficial genes which can decrease trivalent arsenic in grains. Production of rice grains that possess a high organic/inorganic arsenic ratio could help to reduce inorganic arsenic contamination level.

Development of a toxicity database is very much essential for different rice cultivars and other crops for setting standards for arsenic in flooded and non-flooded soils. The low levels of inorganic arsenic detected in Chinese rice could be important in rice cultivation to reduce the dietary exposure (Williams et al., 2006). Phytoexcluder crops for arsenic can also be developed through laboratory techniques or through proper identification of existing plant species for growing crops in arsenic contaminated soils without absorbing arsenic (Hossain et al., 2008). A search should be made for locally-adapted wetland plants that could extract As from soils during the monsoon season when deeply flooded.

7. Conclusion:

The overall scenario indicates clearly that the bioavailability of arsenic in rice and other edible plants must be addressed to understand the importance of arsenic exposure from these food sources. The importance of rice in food security in India and Bangladesh and the high dietary intake of rice indicate that the impact of arsenic in groundwater on rice productivity and quality should continue to be carefully monitored. Arsenic may serve as essential role in growth and nutrition, but excess intake can be lethal for a population. Intensive investigation on a complete food chain is urgently needed in the arsenic contaminated zones, which should be our priority in future researches. Differences in environmental and socio-economic conditions within the contaminated regions and within countries need to be considered in a sustainable manner.

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Sd/-

(Goutam Banerjee)

We are highly disturbed regarding AMRI hospital fire deaths taking a toll of 94 lives and hooch tragedy of Magrahat, 24 Pgs (South) that toll 171 lives. This is total administrative failure and we should attack the roots of the malaise. We are very much with the bereaved families.

The Wardha Scheme of Education : A Symposium

Dr. Meghnad Saha

[Dr. Meghnad Saha (1893-1956) was an eminent teacher, scientist and astro-physicist. He was deeply concerned with the recurring disastrous flood in India and wrote extensively on the flood problem and river control by using technology. In fact, the Damodar Valley Corporation (DVC) was the brainchild of Meghnad Saha. His work relating to reform of Indian calendar was also very significant. He served as the Chairman of the Calendar Reform Committee appointed by the Government of India in 1952. Being a severe critic of Mahatma Gandhi's concept of Charkha and Khadi he believed that large-scale industrialization was the only solution for improving the quality of life in India. He wrote many essays on the utility of science and how to use it for the benefit of human society. As he was interested in Indian history and culture contemporary educational issues drew his attention. Readers of this article will come to know that he had no faith in Gandhiji's principles of Basic Education and his antipathy towards modern machines.

Shri Nirmal Chandra Sengupta, editor of the *Presidency College Magazine*, Silver Jubilee, No. 2(1938-39) invited comments on "The Wardha Scheme of Education" from Sir Albion Banerjee, Dr. Rameshchandra Majumdar and Prof. Meghnad Saha and published them under the title "The Wardha Scheme of Education : A Symposium." The first article was written by Sir Albion Banerjee (pp. 217-228), the second by Dr. Rameshchandra Majumdar (pp. 229-234) and the third by Dr. Meghnad Saha (pp. 235-236).

Spelling and punctuation are kept unchanged.

Malayendu Dinda]

Llang Dh'i-Ch'ao, the Chinese philosopher, defined in very pointed language the object of education thus : "Education is the means by which the state nurtures its own kind of people, welding them together as a whole that they may be independent and struggle to strive in the world where victory goes to the fit and defeat to the unfit." We may judge from this point of view the Wardha Scheme of Primary Education. Any study of the scheme will show that the society which the new system visualizes is one of peasants and small artisans who will be inspired by the Tolstoyan ideal of service and of Christian virtues. The education will be imparted through basic crafts – spinning and Khadi – and with the aid of day-to-day experience of life. The adoption of Hindusthani as the second language will enable the people of different regions to understand one another quickly and without difficulty.

The basic principles of this education was formulated long ago by John Dewey, the American educationist, and applied with remarkable success in the remodelling of the American system of primary and secondary education. But while Dewey's system aims at a society in which the average individual will be familiar with the technicalities of the modern mechanical civilization and at adult life will find himself perfectly at home with its ways, the Mahatmaji who inspires the new scheme will have nothing to do with the demon of machine. After assuring the country of the emergence of a perfect society and everyone of a living wage and the right to freedom, the Mahatma expresses himself against the machine in no uncertain language:

And all these will be accomplished without the horrors of a bloody class war or a colossal capital expenditure such as would be involved in the mechanization of a vast continent like India. Nor would it entail a helpless dependence on foreign imported machinery or technical skill. Lastly, by obviating the necessity for highly specialized talent, it would place the destiny of the masses, as it were, in their own hands.

Even ardent admirers and followers of the Mahatma find it difficult to support him in his denunciation of the machine and of the machine age[1]. If we apply the test of the Chinese philosopher, the system of education advocated by Zakir Husain Committee will not make Indians fit for the present age.

To us, scientists, it appears that the Mahatma's system lacks in progressive vision, that is to say, it does not indicate how villages are to be linked to the cities, and how the industries which are indispensable for the nation's life and for the body politic (those connected with transport, communication, power, essential chemicals, etc.) are ever to be managed by Indians for the benefit of India. Apart from adopting a policy of laissez faire with regard to these urgent problems, his whole attitude towards the machine and the modern city-civilisation is one of defeatism. He looks at its evils but does not try to understand its mechanism of work, and he starts with the inner conviction that the machine civilisation must be intrinsically wrong. But may we submit that it is a wrong reading of history to say that the mechanization of a vast continent like India would necessarily entail a bloody class war, or colossal expenditure, foreign experts or foreign machinery.

It is true that the Industrial Revolution in Europe caused great social dislocation and political unrest, but this was due to the fact that the discoveries of science were first utilised by capitalists for their private gain, and statesmen and leaders of thought were slow to realise their repercussions on society and at first adopted a policy of laissez faire towards them just as Mahatmaji proposes to do now. Hence it is that Industrial Revolution in the West expressed itself in class war. It was when the problems could no longer be avoided that western statesmen began to introduce their beneficient but contentious legislation in order to achieve social welfare. But it is the best of statesmanship to learn from the lessons of history : Look at Europe's apt pupil, Japan, which has introduced the Industrial Revolution without the horrors of a class war or without having to borrow foreign technicians or foreign capital. What has been achieved by Japan can also be achieved in India provided the nation will so. It would be a happy day for India if the Mahatma can overcome his attitude of defeatism towards the machine, devote a little time to the mastery of the technique of modern civilization, and then makes up his mind. We are quite sure that he will find that the machine, instead of being man's master, can also be made his slave, and that it is possible to utilise the machine for promoting social welfare much more efficiently than with the system advocated by him. He can then lead the nation to the right track with his usual energy of conviction and driving power. Otherwise we feel, that by diverting the attention of the nation from the only path which holds out prospects of relief against the present problems of poverty, unemployment and defencelessness, he will be committing what we may describe by the oft-quoted phrase as a "Himalayan Blunder".

1. cf. Prof. Nripendrachandra Banerji's review of the Wardha Scheme in *Science and Culture*, Oct, 1938.

Source : *The Presidency College Magazine*. Silver Jubilee. Vol. XXV, No. 2, March 1939, pp. 235-236. PAS

Rehabilitation of Chronic Psychiatry Patients

Basudev Mukherjee

Generally in major psychiatric problems inevitavely there would be a chronic residual state after long continued treatment. Then we have to think the next phase of treating the patient that is his rehabilitation. In a word we have to think how we can mainstream them so that they can be self-dependent and look after for themselves as far as possible. It is natural that they would not be like other normal persons. They need family and social support and assistance for the rest of their life. But they have to adjust in the mainstream according to his capacity. They have to collect the material resources for survival from this mainstream so that they can improve their quality of life. Because we are a poor country and densely populated and it is not possible to make any separate arrangement or infrastructure for this marginal people like chronic psychiatry patients.This can only be possible if this chronic patient remains in the mainstream in his family, in his community and his community has to be prepared to accept him as a bonafide member. In present situation once she gets separated for a long period from the mainstream, from his family from his community she separated for good. It is impossible for her to get adjusted to her community. She always becomes dependent on others for the vital ingradients for existence.This would be the reality if her family is poor and this in fact happens in most of the cases when family members are very much reluctant to receive their chronic psychiatric patient once she gets admission in a psychiatry hospital.

But the problem is if she has to return to his family then she should have at least some amount intact cognitive, emotional, socio-judgemental capacity for meaningful interaction with the other community members specially in the area of feeling, thinking and behaviour. Otherwise it would not be possible for her to maintain her self-esteem. She has to learn at least how she can be self-reliant and she has to be active with the other members discharging minimum responsibility. She should not be a burden to her community. She has to be a individual social person so that she can move indipidently and can participate at all the community activities.Then she has to learn how she can do this.She has to learn how he can compensate her dificits to attain a self-dependency. Of course she earnestly needs her family and at large her community to help her in this struggle. It is fact that she is weak and unstable so she needs community's help regarding training, courage, confidence etc.. Now we have to think how we can make this programe successful.

We know, suffering for a long continued time and taking regularely a considerable number of medicines a major psychiatric patient is transformed into a mentally handicapped person.Specially she fails to actively participate in the social community activities of cognitive aspects. She suffers to initiate any meaningful activities. So we have to think how can we rehabilitate this persons having this cognitive deficits. Whatever be the treatment program it is not possible to cure a patient who is suffering from major psychiatric ailment. At best we can relieve her symptoms and made her to some extent adjustable to her previous environment. Though there is the risk of relapse due to irregularities of treatment and for some causes that are still known to us.

But only the symptom-free condition is not sufficient to participate meaningfully in all the social activities. Our external environment is always changing and one has to apt with this changing environment with her cognitive faculties. There are various activities in this environment with some routine day to day chores and some special occasion like play, festival, functions etc.. She has to integrate with all this activities to maintain his decent quality of life.

But our chronic psychiatric patients after a part of satisfactory recovery generally fail to integrate with all this functions and their family members are either not motivated or equipped enough to handle this painstaking laborious process. So they are drifted to an uncertain fate in this complex situation specially in the urban area. Either they suffer relapse or face a more moribund condition to return to hospital. In this way they are stigmatised, they fail to reach the existing service and there are also various hurdles that obstruct them to get this facilities. They fail to be appointed in any professional works so they remain poor and suffer from worst quality of life. They cannot spell out their problems properly. This are the reasons why the process of rehabilitation of patients of chronic mental illness is so problematic, so complicated. We think this is a challenging task in our poor backward country though we are still community minded at large.

Regarding chronic mental illness we chiefly consider the chronic schizophrenics who remain some amount in residual state. They are the major part of this population if not all. There are some people here incuded like chronic alcoholics or various types of substance abusers suffering from some chronic mental and physical illness. Though in reality we find a large number of population in our community while searching for rehabilitation those who are not chronic schizophrenics. They are persons of personality disorder, inadequate intelligence, behavioural disorders etc..

Any person who is confined in an institution (hospital or prison) for a long continued period for his illness or other reason is not a good candidate for mainstreaming.Due to various reasons this person is recognised as a burden in her family in most of the cases. It is fact that they are poor people and the family is already compromised with proverty and various other socioeconomical problems. Generally this family members deny the charges of this persons. So it becomes a social and moral obligation to shift this patients to an institute and incarcerating him or her for a long continued period.This problem becomes more complicated when the patient is a prisoner. There are a considerable number of prison population who are serving jail term more than fifteen years. It is a most difficult and complex community program to rehabilitate this population. Though we discourage any form of institutionalisation of this chronic patients. Because there is a tendency to keep this patients suffering from chronic ailments for long continued period. But it is fact that longer the period of incarceration difficult it is for mainstreaming. Moreover this institutions of chronic patients are the breeding ground of all sorts of corruption and filthy activities. At any cost we want to avoid this system of rehabilitation and we want to give responsibility to manage this type of patients to the community.

Integration of Treatment and Rehabilitation

Treatment and rehabilitation are not some different issue, they are two sides of a coin. They can act conjointly and act as a complementary to each other. So we can consider the following conditions for successful integration of this two programs.

1. We should take the adavantage of treatment formulated by modern medicine for this chronic

patients. The objective is full recovery as much as possible and to prevent relapse. Also we want that the patient would be symptom-free for a long period.

2. We should take various measures to keep the patient in the mainstream. Such as we should try to train him or reorient him in his previous profession, if any.

3. The social environment of his rehabilitation should be congenial as far as possible and he should get help or assistance in all her works so that she feels less stress pertaining all this function. At least she should get a congenial atmosphere so that she can manoeuvre herself freely and we should not be demanding regarding job responsibility from her.

4. She should cooperate with her daily treatment program and take responsibility specially regarding taking medicines. In this reference she has to know the major symptoms that require special attention on increasing or decreasing the doses of medicines. At least she should get the opportunity to consult with some experts.

5. As far as possible she has to be self-dependent and self-reliant. She should perform all her routine works and should be totally conscious about the maintenance of personal hygine and cleanliness. In any opportunity she should employ herself to earn something so that she should not be anybody's burden. At least she can be a good mental health worker or primary caregiver.

6. The family members who are in charge of supervision of her treatment should know all her long term and short term problems so that they can interfere effectively in any untoward situation. This is the key point in this rehabilitation program.

7. In this program our chief objective is to protect the human dignity and human rights of this chronic mentally ill persons.

In any community health program we start from preventive aspect. So in this rehabilitation program also primairly we have to think what are common factors that match with the general health and preventive aspects also in the case of maintaining good mental health. It has also some special aspect that is only true for mental health and that also should be addressed properly. Though there is no difference of opinion regarding treatment and rehabilitation. Because in any rehabilitation program there are some long term and short term measures that should be followed regarding treatment of this patients. There are also some measures that are unidimensional or multidimensional. Suppose counselling and psychotherapy are equally important like psychopharmacology. So when the psychiatrist will take the responsibility for drug-treatment then any competent counsellor or psychotherapist will look after the psychotherapy part of the treatment program and both should integrate the treatment program sitting together. There should not be any contradiction or conflict regarding this matter. Because the rehabilitation program only can be successful by this joint effort. Because any one aspect of this treatment program is insufficient and incomplete.

Regarding drug treatment the psychiatrists are interested how quickly the sign and symptoms of the patient can be suppressed so that they should not relapse again and again. On the other hand the psychotherapist will primarily look after the socio-psychological aspect so that they can be amalgamated smoothly and without any resistance in the mainstream. There are incidents of bad compliance on the part of the patient, his family members etc.. Once the patient gets relieved from major problems they stopped taking drugs or make irregularities of treatment. Even they do not keep any communication with the doctors. Though we are all responsible for this situation because the people lack consciousness regarding the whole matter on the other hand we are either careless or reluctant to impart necessary instructions to the patient or her

family members. There are also various reasons for this irregularities of treatment such as proverty, ignorance, apathy, lack of family support, adverse familial situation etc.. Now in this case the psychiatrist is giving the leadership so it is his duty to search out what is the reason for this non-compliance. It is the responsibility of the psychiatrist to educate the patient and his family members regarding all the possible outcome of treatment program. This is a time consuming laborious process but for the success of rehabilitation program it is essential and there is no other alternative. It is not possible for a psychiatrist alone to make convenient to tackle all this matters in detail so he would make a team comprising mental health worker, psychiatric social worker, psychologist, counsellor etc. to organise the program. But psychiatrist has to give the leadership about the whole process.

Not only ignorance on the part of the patient and his family members there are other various factors that impede the success of the program such as mindset, attitude, misinformation regarding mental health and psychiatric problems. Even our so called educated section of the population know many things but they also have various misinformation and non-scientific attitude regarding this condition. It is fact that they are not experts so one have to depend on specialists who are continuously in touch of this program.

On the other hand by the process of handeling this kind of chronic patients for a long continued period the family members acquire some unique knowledge regarding the type, characteristics, nature, personality, sign-symptoms of the individual patient. Sometimes the experts fail to attain such know how in specific cases. Because the specialists have some generalised cognitive knowlege regarding their patients. While dischaging professional duties they depend on this knowledge. As it is not possible to know all the problems of an individual patient. They do not come in contact with any person for a long continued period. So they misses various contingent factors that are very much responsible for igniting factors or triggering factors of the whole situation. We may call this as working experiences and some people while managing psychiatric patients develop a high level of working intelligence. But this type of intelligence or exeriences are not sufficient to give desired result. Sometimes this experiences of the caregiver become an irritating factor regarding patient management. However all this problems are implied in this program and that should be handled to the best interest of the patient.

In mental health service traditionally three layers are recognised as prevention, treatment and rehabilitation. But now according to the experts' opinion there is no clean cut boundary regarding this management approach and it is meaningless. In the process of managing psychiatry patients all this three layers can be applied simultaneously. Only thing we have to consider that certain short term and long term measures are applied in proper time and that should be befitting according to the demand of the situation. Suppose drug treatment is an important immediate short term measure and psychotherapy, occupational therapy, rehabilitation planning are some of the long term measures. But all this measures should be started and integrated at each level. Suppose one student become highly emotionally disturbed all of a sudden, creating a devstating situation. Now starting the treatment program immediately we have to consider would it be possible for him to continue the study course in this distrubed situation. On the otherside the time is running and if that student remains out of touch in his study for a considerable period of time it would be impossible for him to catch the situation. Equally this is his period of growth and development and preparation for future. So if he waste any time due to mental illness his advancement would be jeopardised. It would be nearly impossible for him to return to the

mainstream in equal vigour and tenacity. This problem precipitate in a multiplied dimension when we face the case of forced unemployment due to mental illness or even in chronic alcoholism. In that case we have to try our level best to keep the person attached to his job and profession. Once he has been dislodged from his position he has to face a vicious circle of poverty, abence from work and overall degradation from the quality of life. Certainly this would hamper his treatment, recovery, rehabilitation etc..

It is the duty of the psychologist and psychiatry social worker to acknowledge themselves much more regarding socio-psychological situation of the patient so that in time of rehabilitation planning this information would be of much help. They should integrate their knowledge with the treatment program lay out by the psychiatrist. As psychiatrist is a busy person so it is not possible for him to manage the whole matter. It is the responsibility of the others in the team who would actively participate and appraise the situation to all persons concern to develop an integrated approach of the management team. For each individual patient they should take the decision jointly sitting together and everybody should propose his plan in that meeting so that the rehabilitation program can be integrated withen the large scale community and the person concern can be kept in secured, supervised condition. The whole thing can be integrated in the following manner in three layers.

A. Prevention

1. Universal measure: It is pertinent that the children in their period of growth and development should get an integrated, emtionally balanced family structure without compromising the basic requirements for thrive. Only in this way she can develop the standard of her quality and would not indulge herself for any derailed or delinquent behaviour mixing with a bad peer group.

2. Special measure: If the person is suicidal prone then it is the duty of the caregiver to contact with his family members to appraise the overall situation.

3. Special measure regarding sign-symptoms: If the patient is hallucinating and he may injured somebody under the influence of hallucination then some protective measures should be taken to restrain him from any accident.

B. Treatment program

1. Accurate diagnosis of the disease so that it should be treated properly for earliest recovery.

2. Immediate intervention with treatment so that the sign-symptoms disappear quickly. With this we can gain the confidence of the patient and his family members for earliest recovery and easy mainstreaming.

3. We have to see whether she has any general medical problems and that should be treated accordingly.

4. We have to take all measures to prevent relapse of the disease. In this respect there should not be any irregularity of taking drugs. Sometimes patient stopped taking drugs due to the suggestion of the family members for some adverse reactions of the drug. Because psychiatry drugs are notorious for their side effects. But medicines should be continued at any cost specially for the major psychiatric ailments and if any untowad situation arises they should contact with the psychiatrist or psychologist.

C. Rehabilitation

The patient should be brought back to the mainstream as early as possible. We have to keep in mind that the life situation is changing very fast so if our patient remains out of touch for a long period it would be difficult for her to adjust this changing situation. As a consequence it would be

nearly impossible for her to become self-dependent to maintain her previous quality of life and always she has to depend on others for bare subsistance.

Drug Treatment

The important positive effect of drug treatment is quick relieve from the sign-symptoms and if the patient continued medicines, generally there is least chance of relapse. On the other hand the positive aspect of the psychotherapy is it helps the patient to integrate with the family, society, profession, job specially with all the interhuman relationship. However in any way we should not treat them separately because they are interdependent and complementary and when they have been applied conjointly we always get synergistic effects. For this reason only in any mental illness both of this system of therapy should be applied conjointly. Such as in any mental illness patient's family members should be sensitised about the illness from the day one. The consequences of this treatment program, the usual course of this program, our expectation from this program, side effects of the drugs, adjustment of drugs in various adverse situation - all this matters should be known in details by the family members and caregiver. Otherwise they will not be competent enough to prepare themselves for the future. All this problems magnified when we face a major psychiatric problem. It needs a group of people with various working experiences to tackle the situation. Because it become very much difficult to appreciate some good advices in this sudden, disruptive, acute, devastating situation of major psychiatric illness. Moreover it takes time to be educated in this unprecedented situation. The whole situation is so much overwhelming that the family members give little attention for the good advices. They at most want to get ride of the situation at earliest possible opportunity. They are all preoccupied with the manifested sign-symptoms of the patient.

Generally it has been seen that a considerable number of patients do not follow the prescription properly. It is known to the psychiatrist or psychologist but they show least interest to correct this behaviour in most of the cases. They think that it is their responsiblity to follow the prescription. So sometimes total treatment program turned into a farce as nobody has any time to look after the matter meticulously. Though any mental illness is a chronic problem and it is not like some common disease as viral fever or diarrhoea. So it takes time to resolute the whole matter of mental illness and if we follow a scientific guidline of management we get immense benefit for the patient. Specially we are now very much concern about the cognitive aspect deterioration of the patient suffering from mental illness. As this illness create much deterioration even after applying the antipsychotic drugs. In this case we have to measure finely, judiciously how we can provide maximum benefit to a patient so far his cognitive function is concern. It is not an easy task to adjust the doses or to apply the appropiate drugs so that the patient become alert and cognitively active in his life situation. This is the hallmark of any rehabilitation program of the chronic mental illness. To develop this acumen we need a teamwork comprising all the members concern with the treament of the patient. This team is only capable to supply all the relevant informations regarding the patient so that we can proceed for the further step of rehabilitation program.

Sometimes the family members or the patient himself prefer the mode of treatment either treating with drugs or doing psychotherapy only. But if the situation demands otherwise then there will be a chaos and neither the psychologist or the psychiatrist would be competent enough to override the patient or her family members. However in this case we have to take time and we

have to try how gradually we can educate them so that they would appreciate the whole situation and there should be no irregularities of treatment. We received various complaints that mental illnesses are incurable even treating it exhaustively. We admit that to cure a mental illness is not an easy task but equally we do not cosider our shortcomings and various contignent factors that are obstructing our planning with multifactorial causal effects. Even we are not ready to admit our gross negligence.

There are some additional points. Mostly our people are poor, backward, illiterate, ignorant to that extent that they cannot communicate freely of their problems to others. Naturally it becomes an upheavel task to costruct the whole situation of a person's mental illness from some piece-meal informations from the patient or the family members. Where the patient is not accompanied by his family members the situtaion is beyond our control, even the family members are not equipped enough to depict the whole situation. Communication is a training and our people mostly lack this training since childhood. We consider this problem seriously of the psychiatry patients as they are often less communicative due to their illness and the treatment program depends on good communication as there are no evidence-based measurement of the sign-symptoms. But still we are not conscious enough to overcome this problem though it is a huge wastage of time and labour on some inadequate information and all our patient management program bound to suffer. This is also important in case of rehabilitation program. Because in this case specifically we have to know what are the resources, support (familial, social) available for rehabilitation of the patient.

In this respect we can recapitualte the importance of taking medicines in regular basis. Because in any chronic mental patient maintainenance of an amount of medicines is part and parcel of the rehabilitation process. But it is difficult to take medicines on regular basis. Patient may has some preference over certain medicines because he feels better after taking this medicines. This may be that he feel less side effects (suppose sleepiness)or untoward problems by taking this medicines. They also suggest their preference to the psychiatrist and he prescribed medicines accordingly. It is fact that same medicine creates different actions on different people. Everybody do not tolerate the same medicines or same adult doses. Also there are some patients who do not develop any ideosyncracies in any medicines. There are negligible differences of the chief antipsychotic and antidepressant drugs commonly available for treating our patients. They are equally effective. Only we have to see which patient can tolerate which medicine and this is an important reason why patient discontinues treatment. However this are the salient points we have to keep in mind while treating a chronic patient with medicines.

1. The patient and his family members should know why there should be no discontinuty of taking medicines.
2. Every medicine is a chemical molecule and has some advantages and some disadvantages. Now we have to select the drug which is more advantageous for the patient specially regarding side effects, cost etc.. Of course there are some situations where we have to prefer some medicines knowing fully well its adverse effects.
3. In that case where we have to apply certain medicines for long continued period, we have to know the side effects and we have to acknowledge it to the patient and his family members.
4. If patient complaints of any side effect (suppose a teacher complaining of fine tremor in hands that creating problem to teach a lesson through black board in the class room), we have to see how it is interfering his daily routines.

5. We have to think how we can alter or change the medicine to avoid any untoward effect.
6. We have to know the patient is complaining of any new problem or it is his old problem.
7. There are certain medicines which take at least two weeks to attain effective blood level for opitimum activity. Say in the case of antidepressant, it takes at least fifteen to twenty days for creating optimum effect. So if it is applied to any depressed patient specially if he is suicidal then we have to be cautious and his family members would be informed accordingly. The patient should be counselled that he has to bear the sufferings in this interim period.

Chronic mental patients have to take medicines for a long period and sometimes like the patient of hypothyroidism, heart ailments or hypertension. Sometimes it become difficult for him to purchase or procure this daily doses of medicine. This is one of the commonest causes for irregularities of treatment. In this case we have to consider what the minimum maintenance dose would be suffice to prevent relapse and control his symptoms. Naturally we have to consider medicines as essential nutrients.

Social Rehabilitation

Recently there are sea changes about this concept and we have to discard various misconceptions. Previously we thought it is the primary responsibility of the family members or patient to regularely keep contact with the psychiatric institution or any hospital as and when necessary and receive from it their required service. And the mental hospitals would act accordingly in the out-patient and in-patient (for acutely disturbed patients) units. Years after years this was the standard procedure. Few conditions have changed the scenario. Previously there were joint family and it would become easy to cope such type of one or two family members in a big set up. But now the families are small and if both the parents are working outside then it would be very dificult to absorb such patient in a small set up. Still the poor patients or the patients of poor families suffer most because there was nobody to look after him. Still the problem is very much reality in our community but we feel some changes. Some movement is going on where it has been recognised that we have to deliver human rights to this marginal section of population. So there the question of rehabilitation arises and it is the perrogative of all the persons concerned that how we can return their dignity of this group of abandonned people. Gradually it has been realised that the process of rehabilitaion of this chronic mentally ill patients are not an easy task. So it cannot be applied flately for all the patients. We have to make arrangement for each and every patient separately and it is the meticulous work of a team comprising general physician, physician specialist, psychiatrist, psychologist, counsellor, psychiatry social worker, mental health worker, caregiver, family members, social activist etc.. All the team members have to perform their responsibilities harmoniously to make this program successful. Somebody has to give leadership in this whole program and experienced psychiatrist is the fit person to carry out the movement.

Marraige

Marraige to a chronic psychiatry patients is a most intricate and difficult proposition that have to face to a psychiatrist and psychologist. Whoever take the decision he or she takes it for granted that there should be every possibility for breakage of marriage. Yet we have to decide whether the person would marry or not. Because all persons do not suffer from same disease and all diseases do not affect equally to all persons. Each person has his own life style, temperament, cultural and educational background, family structure, quality of life, discipline in the family etc.

and it is unique. So it is impossible to generalise all this things and it is impossible to comment on the given situation. Apart there are differences in rural and urban family set up. However if somebody has to take the decision of marraige of his family members who is suffering from chronic psychiatric ailments then he has to consider the physical, mental and social status of that person in details and consult with some experts and would take the decision. Because we have to remember that marraige and specially to start a family is a stressful event. Commonly it is believed that marraige will absorb the stress but it is huge misconception. All the psychiatry problems can be aggravated after marraige. It is very difficult to adjust a chronic mentally ill patient in a new family.

Generally onset of psychiatry problems begin at the age of around twenty years and after suffering for four five years he or she settled in a chronic residual state. We can say this is a fragile, apparantly balanced state of a major psychiatric illness. This is a chronic residual state where the person has to abide by certain norms. Actually she is now not free from diseases. Meanwhile she has lost four five years that was most important for preparation of her future life. Seeing no other way the guardians prefer to give her marraige and invite the disaster. Sometimes they keep the decision secret from the psychiatrist also. She stopped taking medicines and plunged into very stressful situation of a new family. She suffers from utter degradation and automatically the tie is torn in most of the cases.

In this tottering condition the women folk suffer most due to social reasons. But in comparison due to the male hormones the male members are worst sufferer due to diseased condition. Though nature has saved the females to some extent with the introduction of female hormones and they do not suffer in the same intensity like their counterpart. Apart our family is a small area where she has to manoeuvre specially with day to day household chores, child rearing etc.. So somehow she can manage or adjust the situation if she does not suffer from disorganisation. Her parents will demise one day then where she would get the shelter, who will give her the security? Thinking in this way her family members arrange the marraige. They keep it secret as if it is known that she has any psychiatric problem then nobody will come forward to accept her. So the problems become much more complicated.

Recently we are facing the problems of small family norm where after marriage both the members have to share equally with household responsibilities independently. If any of them suffers from chronic psychiatric ailments then it become nearly impossible to keep this marriage as a viable unit. It is bound to crumble. As the behaviour of the newly married bride is not normal that become obvious. So the otherside thinks that they have been cheated by hiding the mental illness of the girl. Comparatively in a large family there are various means and ways to adjust the shock or stress developed due to this kind of aberrations. Though still we have some fixed ideas regarding the behaviour of a newly married bride. So if the behaviour of the woman is not befitting to that set ideas we do not accept it. Moreover if the person is gainfully employed then he or she would get some different status in her family and she can somehow manage the whole affair. But in most of the cases she is unemployed and she has to face separation or divorce. And it is become increasingly difficult to maintain her life at her father's home. Sometimes compassionately sponses bear each other to an extent if any one of them is mentally ill. But when the problems cross the limit breakage of the marraige is inevitable. Howeven we admit in some restricted cases marraige may be a form of rehabilitation specially in rural area. But in most of the cases it creates disastrous effect specially on the part of the female. So in most cases we have

to judge it individually and to see how much strength is there within the two families and their members and how much they are weak. If the spouse is compassionate enough to accept his or her partner apart from every shortcomings then there is a possibility to keep the marraige intact. Again if the woman is taking medicines regularely then we have to consider what should be done at the time of pregnancy and lactating period. We have to make a subtle balance keeping everything in mind.

Criteria of soundness of mind

What should be the conditions of sound health? Is there any scale to measure all this criterias? Is it possible to make any scale? As the chronic alcoholics and substance abusers are measured through some criterias whether they can be a fit candidate for rehabilitation. But it is nearly impossible to make some criterias for the major psychiatric illness. Generally we consider the period of any major illness is like a spell and after suffering in that spell the person becomes fit and later joins in the mainstream after full or nearly full recovery. He becomes as like before and there remains no trace of any aberration. But after major mental illness it is not an easy task for the person to integrate with his family in the same tune as before. Certainly he will exhibit various deficits specially intellectual or cognitive. Even sometimes his or her employer does not accept his quality of work. Yet he is destined to discharge some duties and responsibilities. Here considering every details we have to see what are the deficits of that person that have to be covered.

Conclusion

Not everybody suffer from mental illness in our society, only a few person suffer from this illness. This proves that some persons are vulnerable biologically or psychologically so that they cannot endure the stress of the external environment. So they precipitate in some mental illness. In every society there are system and method to absorb this amount of stress. People assimilate this systems so that they can remain sound in mental health. This is a normal natural procedure. Whereas the psychiatric patients fight to their level best to cope with all this problems but fail and if there are any system of giving assistance in our community then it has been seen that this chronic patients can maintain there daily routine to considerable amount. At least he can struggle with this assistance to reach a certain level. So we have to make this assistance available in our community. This can be documented in the following way -

A. The services that were available to him previously are still available.
B. Pharmacological treatment, psychotherapy, counselling all are regularely applied to him.
C. There are no irregularities of supply of medicines and he is receiving training to become self-sufficient as much as possible.
D. Family is very much supportive and he gets all sorts of assistance according to his requirement.
E. When he is in better position he tries for gainful employment.
F. There are opportunities to admit him in the mental hospital if he becomes acutely disturbed.
G. He is getting a rehabilitation-friendly environment in her community.

If we can maintain this arrangement we can expect this four types of outcome.

1. Gradually he is completely cured.
2. He is in a long period of evenly balanced condition.
3. His illness has relapsed.
4. There is no sign of improvement of her illness.

For the caregivers there are few signs which they give utmost importance in respect of improvement of the patients such as -

A. The amount of sign-symptoms are present and the intensity of the sign-symptoms present at the time of relapse.

B. She can manoeuvre herself independently.

C. She can discharge any responsibility independently.

D. She can keep her quality of life upto a standard.

There are increasing pressure why the results of the successful research works cannot be available in the community mental health program. In our poor backward country this pressure has become more complex and hard. Because a large number of mental patients are not actually covered under the community mental health program. And the majority population depend on state mental health infrastructure that is negligible in comparison to our patient load. On the otherhand a few families have the ability to continue treatment under the supervision of private enterprises. Because the private system is too costly for our poor patients and they will not be able to afford this arrangement. So our goverment has to come forward for a solution. Constructing some mental hospitals are not the solution of this problem. We have to make a community mental health approach.

On the contrary there are tremendous research going on regarding genetic pathology, medicinal therapy, psychotherapy regarding psychiatry patients. We are getting this news but cannot afford to implement the fruits of this important research works mainly due to lack of mindset and poverty. In this regard we have to face three important questions -

1. Are our mental patients getting exact services they required?
2. Are there sufficient opportunities and resources of their getting services?
3. Are the resources implemented for their services are good enough to provide desired result?

It is very difficult to get an answer as a general proposition. Because each and every psychiatry patient is different, his history is different, his illness is different so his course of treatment would be different and its outcome would be different. They are self-similar. But they are common in maintaining their quality of life. So we have to analyse in the question of rehabilitation how is their quality of life and how do they are maintaining it in our backward socities. Whatever be our good, honest, sincere endeavour poverty kills all our efforts. Over and above there is lack of mindset among all. It is seen that providing all resources we may not get the desired results. However it is not possible to give the answer that why we are failing? It is multifactorial in causes so that we have to analyse in details for worth of every individual effort. And we are thinking in that line regarding integration of rehabilitation in chronic mental patients within our community. We have propsed the following ten points for further continuous follow up to make this program success.

1. Do the patient is getting sufficient assistance from the family and community? If not why?
2. Is he a substance-abusers or chronic alcoholic and a failure in deaddiction program?
3. Though he is suffering from major psychiatric illness but responded excellent in the first effort.
4. He is responding to conventional antipsychotics.
5. He has good compliance record.
6. He is getting much benefit from psychotherapy, counselling, occupational therapy etc..
7. He has been employed and maintiaing his job-responsibility satisfactorily.
8. He has no functional disorder or psychosomatic problems.
9. His premorbid professional record is good.
10. He gets the mental health service opportunities as and when require. PAS

From the Desk of the Mind-Painter

The Mind of Ruler

Madhabbabu is an influential Marxist leader of this area. Once upon a time he was so much powerful that he could make or break anything through the act of beckoning with the finger. Even his act of beckoning may stop the functioning of any school managing committee. Everyday morning he gave patient hearing of various appeals and demands of innumerable people and solved their problems. Now he has to face less people at his residence. Even the tough and strong police officer of a police station would received transfer order to a remote place of Sundarban if he has any confrontation with Madhabbabu. In his presence even the D.M. and S.P. address him as 'Sir'. His wife who adore herself with terracotta ear-rings, is also quite modern in behaviour. She is also a local leader of the women wing of the party. The history of Indian Peasentry can be found on his desk and the strong facial expression of wall clender of Stalin and the wooden horse of Bankura are dressed and lay artistically. He considers Marxism as a science so a Marxist Party cannot make any mistake. He gives leadership in his area at the time of general election. Neither SP or MP or either Minister, he is the last word in his area. He has his own arguments regarding jamming booths and casting false votes. So long people are not mature enough to fight the evil forces of this society, it is impossible to exist within this fragile democratic forces. So considering the future horrible days and for a greater cause we have to oppose this evil power by organising our power through our caders. He is helpless if anybody feel pain in this matter. Discussing all this to a group of listerns a flick of smile become obvious at his bettle chews lips. So increasingly day by day he has to depend on such people as 'Kalu', recognised by a fine golden chain at his neck, scar-faced 'Bhola' and left arm amputed Bapi. Those who join the procession lead by him try to mollify the wrath of Madhabbabu. If Madhabbabu is annoyed with somebody then he is doomed. On the other hand if he pleased with somebody he will be be a lucky for future prosperity. His request in a soft tone though rumbling is a manadatory order to anybody. He is the President of Riskshaw Union of the district, Teacher's Association, Fish Vendors Association, Democratic Writers' Asociation, Refugee Struggle Committee etc.. So all this unions are strong and stout. It is a heresay that a leaf has to take his permission if it wants to shed from the tree. People say that if he feels uncomfortable with somebody Madhabbabu just expresses a mild smile placing his fine embrodiered scarf properly and in the next day early morning everybody would find the dead body of that person lying in a high drain.

I felt a bit surprised, how could I help such a leader like him.

- Oh you - I just try to make myself steady -.
- Yes there is a familial trouble.
- But why you have come here, I am available at your doorstep clinic.
- There everybody will observe that I am seeking your advice.
- O. K. now say what can I do for you?

Imposing Madhabbabu wiping his face to clear the sweat, confirmed that the door is

properly closed then started to depict his story - In our joint family a dispute has cropped up with my younger brother regarding ancestral property. They never disrespect me and there is no reason to do that. But now a days - uttering this much he burst into laughter due to rage. They have informed the matter to the local secretary whom I have created. And they also are so audacious to call me at the local party office. They have called me who was once joint secretary of the district committee? They can easily come to me my residence to discuss the matter.

- But you have made this system. You call people at the party office to solve their problems.

- So that would be for me also? Madhabbau began to shiever in rage.

I suggested - but they are following your system, they are actually obeying your principles.

- Actually do you know I have managed the misdeeds of many who are now in the local committee. And today they have assembled to give a verdict on me. Do you know, I myself become so restless that cannot sleep at night. Once I have solved everybody's problem and today I have to make some complaint to them for fair judgement. I have to appeal Bapi or Bhola. Still they use my name for gathering at the procession. Still they invite me at the meeting to preside just to gather people.

-But you have to accept this as party discipline. The Prime Mininster is bound to attend Ld. Court summons.

- Do you consider court and party office are the same apparatus.

- See, for us, for the common people court and party office are equally powerfull. We abide by its verdicts. Even the officers of the police station suggest us to settle the matter at the party office. How you can break the discipline created by you.

- No no doctor you are not understanding it properly. You cannot make a generalisation in this way. I cannot sleep for many nights but unable to purchase the sleeping pills from our local medicine shop. You just make some arrangement so that I can sleep at night. This people who are big promoters, highway toll collectors, bheri capturers at the gun point are now calling me for trial?

- But you have created these people. When they assist you at the time of general election at the polling booths wearing a cap, taking a button or revolver in hand then they are your comrades. And when they turn their revolver to the people they are antisocials. However if you are feel shocking regarding this matters then why you are not leaving the party? Many of our people consider party as a furious ruler and you are not exempted from it.

- Actually it is impossible for me to make you realise the whole matter. If I realise it on myself alone, then socially it will not be possible for me to remain secure in this world for a single day.

- If this is your fate then is it not useless of struggling for so many days in Marxist pathways? Again you consider that Marxism is faultless because it is science?

- Actually every party face a period of crisis, so it may be that our party is passing through that critical period. Now we are old enough so anybody can volunteer to take the leadership after gripping the whole situation.

- It is said that even in your time people were heavely terrorised, so donot you consider yourself as an initaitor of this sort of continuous errors?

- Listen, Stalin had to take many firm decisions to protect socialism of great Soviet Union that had been created by people's revolution. Many persons think Stalin as a leader of genocide. But Stalin had no other option. If Stalin didnot follow this path socialism of Soviet Russia, acquired by people, would not last long.

- But how could you call it a great work if it was done by slaughtering innumerable people.

- You would see that one day history would speak the last word regarding Stalin.

- But you say that man creates history. Otherwise the history we read is the history of Kings. We are still lack behind to create the history of the people. So the true history may remain silent for many more days. However we are unnecessarily draging our conversation. Actually the common men had expected that you should not take revenge by performing rigging in general elections. You should organise free and fair election. So that everyone can caste his opinion without fear and that is the foundation of democracy. Each and every party are shouting of democracy but they are bold enough to face the fair election so that they can establish the true democracy. This is the reason that we are unable to reach the essence of democracy. The same hooliganism, throwing bombs, showing red eyes and capturing booths are visible everywhere. In this state only you people can create such an environment, a culture of fair election as you are ruling this state for a long eriod. The welfare of the people, democracy this are the bone of contention. But if somebody distanced himself from this democratic struggle and engages himself in the politics of sheer power struggle then they will jeopardise themself psychologically if they fail in the power struggle. There is no alternative.

Suddenly Madhabbabu changed the topic and start a new topic, " O. K. what is your stand regarding transmigration."

- I cannot imagine that you being a Marxist would raise such question regarding the existence of transmigartion.

- Why, are you sure that there is no transmigration?

- Yes, certainly. There is no transmigration.

- What are you saying, there is no transmigration then we will not come again in this earth? Never?

Once imposing-faced, terribly powerful Madhabbabu now panickised with eyes opened wide, turned pale and grim. I clearly visualise fear of death in his eyes. Once terrorised by him this panic-striken eyes were seen to other people.

I said, "I feel wonder seeing this unscientific mental state of you. You are saying Marxism is a science and suggesting people ought to be scientific minded. So you are claimimg as scientific minded people but when you are facing the question of final departure then suddenly embracing transmigration."

- Why, has science proved that there is no transmigration? Then how can you are sure that it is an outright deception?

- But you cannot say it as true either. May be we can keep mum in this matter. What I meant to say, if we override the proof yet we have to follow the arguments and assumption in reference regaring the proof. It is beyond doubt that we loose our consciousness after head injury. So our consciousness is within our head. After million of years of some primordial condition we have reached in this subtle, higher level of sensation due to interaction of external environment and conditions of the living cells are the foundation of this consciousness. Just think what you visualise waking from a deep sleep! During sleep you are nowhere.

In deep sleep if you are no-where, suppose it is continuing, it become endless and that we call death. You will not realise that you are nowhere. As the persons who has been killed by your partymen, would not realise that they are nowhere.

Then listen Madhabbabu it needs courage to admit that there is no transmigration. Of course we need courage to think that we will never return to this world. Due to lack of courage we hidden our face and try to feel in imagination that there is transmigration. In various ways to defend transmigration we search for arguments. We fail to remain conscious regarding science in this aspect. We want to keep the concept of 'soul' or 'life' separating from our body in a hidden compartment to secure our mental state. But alas, life is not anything like that, so that you can keep it as it has been kept in this form due to interaction of millions of cells. Cells death are its death. Why your mind now want to believe in transmigration? So long mind and brain was conditioned in joy and pleasure at the helm of power you did not require the thinking of transmigration but now its void has become intolerable. So long you had entered into the dark lane of power and to save your society and politics you have defended yourself with various arguments. You have defended that hand-amputed Bapi, sacr-faced Bhola are essential to keep you in power and you have to accept it for a greater cause. Days after days you have shifted from actual contradiction and arguments and you have alienated from peoples' heart and secluded in the ivory tower of power. Yet whenever you have been dislodged from the circle of power. You have started to think that the internal condition of the party had become hell. Can we call it political consciousness? Whenever the intense pleasure of this power, satisfaction of breaking the committee one after another at the act of beckoning, this intense emotion vanished from your brain there you have been exposed with severe void for rest of your life. You can only win-over this void by transmigration, thinking that let this life is lost again I shall get at least another life.

All the time you speak of 'people' but do not try to identify with the people, you have ruled them only from above. The collective roaring of slogans at the procession lead by you have made rippled in your chest but you never enquired that there are helpless thousand cries of many people mixed in this sounds. No, you can never overcome this crisis through transmigration. You do not know that you will not return. If you depart with a false assurance that you would return then the moment of your departure is a spate of lies. If you do not face the truth you cannot solve your problem of insomnia.

Now if you can think again to work in some democratic platform! you can do many works using this platform.

-Oh If this works are against our party then it would be difficult for me.

-If you have not that amount of courage to face the truth in this moment then I shall suggest you to join with some safe social works. This is not for power, to join with many more people. Gradually you will build your own sphere. And those who are creating disturbance in your party the time will judge them. Gradually as your social status would be based on truth then you will get many truthful man around you. Then if you have to take a stand against your party, you will not hesitate and in this way your 'insomnia' would be vanished. Then you will not consider death as dying. You will consider that you are a part of everybody in this earth.

Dr. Goutam Bandyopadhyay PAS

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It is an excellent journal of education published and edited by a group of educated people, in line with its previous reputation.It is fact that maintaining this standard they can compete with any national level journal.Here we regret that we have to extend our ideas in a foreign language. But there is no alternative to interact with other people in higher education or methodology in our multilingual country. However *Anwesa* serves our purpose of long standing demand of a journal of education. We expect the erudite scholars of our community will be attracted and show their interest to enrich this journal. We hope *Anwesa* will grow gradually to its highest esteem.

Now something about the articles that may create anybody's professional jealousy. A well edited presentation of some beautiful ideas covering various areas of education. Thanks to the editorial board as they have taken the pain to collect this ideas with utmost sincerity. Actually this is a kind of intellectual creative humming spreading all over West Bengal, subsequently collected, precipitated in the hive of *Anwesa*.It is needless to say that in this age of intellectual torpor specially of Bengal all our colleagues in the stream of education would be inspired, immensly benefited and ignited if they go through this journal.

However now we can humbly put some immanent criticism of the individual articles for future considerations.

1. Ecological Value . . . Actually Sunderban is facing ecological disaster of its own reasons, reasons not lay out due to interference of its inhabitants. But there is no better way than to sensitise our youngstars regarding ecological balance of poverty, insecurity, ignorance, food chain and all other relevant contingent factors. Because at large it is the poverty stricken people of Sunderban who suffer from all the natural calamities. But unless we can improve their quality of life by some standard consistent poverty alleviating program it is useless to make use of any gospel.
2. Trends of Basic Education . . . Problems of CLI (combined literacy index) are not easily understood. Our experts working at the literacy districts comment that overall CLI is of no use regarding the enhancement of quality of life of the masses (so wherefrom they will get the motivation to educate themselves?). Now it is the time to search for some important threads or links that are thwarting the cognitive development of the masses as some gordian knots.
3. Gender Difference . . . No, our society had not paid equal importance to the education of women as stated in the article. On the contrary there are innumerable derogatory remarks against women in our *Shastras*. However we want actualisation of innate endowment of all our children and that needs proper condition to thrive since birth. It is the question of exposure, cultural *milieu*, active participation to develop mathematical cognition.Though it is fact that our girl child are increasingly recognised for their achievement. Thanks to continuous propaganda against all evils (*Buri nazarbale tera muhu kala*).
4. Redefining Swami Vivekananda . . . Actually there is no documented evidence of 'principle of education' left by Swamiji but no doubt he is a great thinker. Swamiji overwhelmed observing the prosperity of the West and he concluded that 'education has made the difference?' But it is not merely education or *Sraddha*, it is science education and development of science and technology that is responsible for the difference. We had banished our rich heritage of sci-

ence education from our country by the leadership of Swamiji's revered predecessor Sankarachyarya and Manu (vide P.C.Roy's *A History of Hindu Chemistry* vol. one).

5. Implementing Inclusive . . . Actually achieving social equity is a political struggle either by arm revolution or through adult franchise. Though due to continious advocacy our people very soon will get a new act on disability that will benefit a large section of population. Thanks to the democratic struggle.
6. Play: the Choice . . . Yes we agree that play is essential for overall growth and development of a child but who will bell the cat? Parents are reluctant, students are reluctant, teachers are reluctant, there is no play ground in the cities, peer group is not available to play so how the child will get his incentive or motivate himself for play? Now it is not the question of shaping sound body and mind with the help of play. Due to lack of physical exercise and bad food habits a huge number of young population are suffering from juvenile diabetes and hypertension and waiting for cardiac bye-pass surgery.
7. Impact of Continuous . . . Yes this is an unique proposition to integrate our school institution with the community but a small caveat, we have immensely vulgarised our poor community with bargaining politics for our narrow interest. So according to the Sociologists working in this field, any interference of this community suffering from high negativism will make some disastrous effect. Actually democracit symbiosis is only possible between two conscious educated informed people which is not easy to find out in our community. However we should try and try so that school and education become an organic part of the community.
8. Be Cool . . . Actually truancy is an emotional problem of the child and before stigmatising him/her as truant we must search for some relevant factors like hunger, poverty, home environment, lack of interest in study etc..Excluding all this factors we can conclude that the student is suffering from conduct disorder or delinquency. For this we need details study of some individual cases. Otherwise we should do some gross injustice to a poor fellow, in such a precarious situation where absence of lavatory is a reason for 'truancy' of a girl child. Again by and large like Western Countries narcotics are not a cause of truancy to our school children.
9. Parental Attitude . . . Excellent article but only parents can not save the whole situation. It largely depends on the available resources and infrastructure within the community. As our normal children are suffering from various non-cooperation regarding their need for actualisation so the question of getting resources from the mainstream for disabled children is a far distant proposition. However various human rights activists, organisations are now working in this field so we can expect some amount of improvement.
10. A Survey on the Attitude . . . Though unpleasent truth but it is fact that we are least interested about our institutions where we pass a considerable number of hours in our productive life. There may be various reasons and everybody has his/her own reasons for this detachment but it is fact that this is a moral legacy that we are inheriting from our predecessors. You call it in an old adage as absence of work culture or anything else but it is fact that we cannot consider our institution as our home or our family. This is a painful situation that an educated cultured people like our teachers create some bad examples that our students try to emulate. So it is not the question of changes of school administration it is the question of change of our 'mindset'.
11. Construction of Linear . . . Very good article indeed though a little bit mechanical as the author has structured the program following Skinnerian behaviourism. In this regard it is our suggestion that author can take help of Vygotsky specially his theories like 'Zone of Proximal Development' and 'Mediation'. However author should get credit for his reference on construction to a modern methodology like computer based Personal Level Learning (PLL).

6 DECEMBER 2010 DRAFT DOCUMENT

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MENTAL HEALTH CARE ACT, 2010

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MENTAL HEALTH CARE ACT, 2010

Ministry of Health & Family Welfare Government of India New Delhi

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Notes :

During the Regional Consultations on the amendments to the MHA, 1987, it became clear that the number of amendments to the MHA 1987 led to multiple repealed sections and this resulted in difficulty in reading the amended Act. This is now written as a new Act because it allows for certain sections to be moved to the front of the Act and renumbering of sections sequentially. Most importantly it makes for ease of reading and use of the Act. The contents in this Act are as discussed in the Regional Consultations and are a continuation from the previous draft amendments (Draft 1 and Draft 2) to the MHA, 1987. Suggestions made at the Regional Consultations have been incorporated into this draft wherever appropriate.

6 DECEMBER 2010 DRAFT DOCUMENT

INDEX

Page

6 DECEMBER 2010 DRAFT DOCUMENT

TITLE : MENTAL HEALTH CARE ACT (2010)

Description : An Act to provide access to mental health care for persons with mental illness and to protect and promote the rights of persons with mental illness during the delivery of mental health care.

Statement of Objects and Reasons :

Recognizing that :

Persons with mental illness constitute a vulnerable section of society and are subject to discrimination in our society; Families bear disproportionate financial, emotional and social burden of providing treatment and care for their relatives with mental illness; Persons with mental illness should be treated like other persons with health problems and the environment around them should be made as conducive to facilitate recovery, rehabilitation and full participation in society; The Mental Health Act, 1987 has failed to protect the rights of persons with mental illness and promote access to mental health care in the country;

And in order to :

Protect and promote the rights of persons with mental illness during the delivery of health care in institutions and in the community; Ensure health care, treatment and rehabilitation to persons with mental illness is provided in the least restrictive environment possible, and in a manner that does not intrudes on their rights and dignity. Community-based solutions, preferably in the vicinity of the person's usual place of residence, are preferred to institutional solutions; Provide treatment, care and rehabilitation to improve the capacity of the person to develop his or her full potential and to facilitate his or her integration into community life; Fulfill the obligations under the Constitution of India and the obligations under various International Conventions ratified by India; Regulate the public and private mental health sectors within a rights framework to achieve the greatest public health good; Improve accessibility to mental health care by mandating sufficient provision of quality public mental health services and non-discrimination in health insurance Establish a mental health system integrated into all levels of general health care; Promote principles of equity, efficiency and active participation of all stakeholders in decision making;

This Act is enacted as follows

Chapter 1 : Preliminary

Section 1: Short title, extent and commencement

i) This Act may be called the Mental Health Care Act, 2010

ii) It extends to the whole of India

iii) It shall come into force on such date as the Central Government may appoint by notification in the Official Gazette. This date shall not be later than 3 months from the date of assent of the President of India.

Section 2: Definitions

In this Act, unless the context otherwise requires :

(a) **Care-giver** means any person who normally resides with a person with mental illness and/or is predominantly responsible for providing care to that person. A care-giver may be a relative (as defined below) or any other person who performs this function, either free or with remuneration.

(b) **Family** means a group of persons related by blood, adoption or marriage.

(c) **Informed Consent** means consent given to a proposed specific intervention, without any force, undue influence, fraud, threat, mistake or misrepresentation, and obtained after disclosing to the person adequate information including risks and benefits of, and alternatives to, the proposed intervention in a language and manner understood by the person.

(d) **Least Restrictive Alternative or Less Restrictive Option** means offering an option for treatment or a setting for treatment which a) meets a person's treatment needs and b)imposes the lowest restriction on the person rights.

(e) **Magistrate** means - in relation to a metropolitan area within the meaning of Cl (k) of Sec. 2 of the Code of Criminal
Procedure, 1973 (2 of 1974), a Metropolitan Magistrate; in relation to any other area, the Chief Judicial Magistrate, Sub-Divisional Judicial Magistrate or such other Judicial Magistrate of the first class as the State Government may, by notification, empower to perform the functions of a Magistrate under this Act

(f) **Medical Officer in Charge** in relation to any mental health facility means the psychiatrist or medical practitioner who, for the time being is in charge of that mental health facility

(g) **Medical Practitioner** means a person who possesses a recognized medical qualification as defined- in Cl (h) of Sec 2 of the Indian Medical Council Act, 1956 (102 of 1956), and whose name has been entered in the State Medical Register, as defined in Cl. (k) of that section; in Cl (h) of sub-section (1) of Sec. 2 of the Indian Medicine Central Council Act, 1970 (48 of 1970), and whose name has been entered in a State Register of Indian Medicine, as defined in cl (j) of subsection (1) of that section; and in Cl. (g) of sub-section (1) of Sec. 2 of the Homeopathy Central Council Act, 1973 (59 of 1973), and whose name has been entered in a State Register of Homeopathy, as defined in Cl. (l) of sub-section (1) of that section

(h) **Mental Health Facility** means all facilities either wholly or partly, meant for the care of persons with mental illness, established or maintained by the Government or any other person or organization, where persons with mental illness are admitted, or reside at, or kept in, for care, treatment, convalescence and/or rehabilitation, either temporarily or otherwise; and includes any general hospital or general nursing home established or maintained by the Government or any other person or organization; and excludes a family residential place if a person with mental illness resides with his or her own family (i) **Mental Health Professional** for the purpose of this Act means i) Psychiatrist as defined below ii) Mental Health Nurse means a person with degree in general nursing and degree in psychiatric nursing recognized by the Nursing Council of India and registered with the relevant nursing council in the state, iii) Clinical Psychologist means a person with a post graduate degree or doctorate in clinical psychology acquired after a minimum two year course from any university recognized by the University Grants Commission (UGC);
iv) Psychiatric Social Worker means a person with post graduate degree or doctorate in the field of psychiatric social work from any university recognized by the University Grants Commission (UGC);

(j) **Minor** means a person who has not completed the age of eighteen years

(k) **Notification** means a notification published in the Official Gazette

(l) **Prescribed** means prescribed by rules made under this Act

(m) **Prisoner with Mental Illness"** means a person with mental illness, detained in a jail or prison, for whose detention in, or removal to, a mental health facility, an order referred to in Section 59 has been made

(n) **Psychiatrist** means a medical practitioner possessing a post-graduate degree or diploma in psychiatry awarded by any University recognized by University Grants Commission (UGC) and/or awarded or recognized by the National Board of Examinations and/or recognized by the Medical Council of India, constituted under Indian Medical Council Act, 1856 (102 of 1956) and includes, in relation to any State, any medical officer who, having regard to his knowledge and experience in psychiatry, has been declared by the Government of that State to be a psychiatrist

for the purposes of this Act

(o) **Relative** means any person related to the person with mental illness by blood, marriage or adoption

(p) **Mental Health Review Commission** and **District Panel of the Mental Health Review Commission** means bodies established under Chapter IV Section 21 and Section 22 of the Act.

(q) **State Mental Health Authority** means body established under Chapter V Section 32 of the Act.

Section 3: Mental Illness

i) 'Mental illness' for the purpose of this Act, means a disorder of mood, thought, perception, orientation or memory which causes significant distress to a person or impairs a person's behavior,

judgment and ability to recognize reality or impairs the person's ability to meet the demands of normal life and includes mental conditions associated with the abuse of alcohol and drugs, but excludes mental retardation.

ii) Mental illness shall be determined in accordance with nationally and internationally accepted medical standards such as the latest edition of the International Classification of Disease of the World Health Organization and;

iii) Mental Illness shall never be determined on the basis of political, economic or social status or membership of a cultural, racial or religious group, or for any other reason not directly relevant to mental health status and;

(iv) Mental Illness shall never be determined on the basis of non-conformity with moral, social, cultural, work or political values or religious beliefs prevailing in a person's community and;

(v) A background of past treatment or hospitalization to a mental health facility though relevant, shall not by itself justify any present or future determination of mental illness and;

(vi) No person or authority shall classify a person as having, or state that a person has a mental illness, except for purposes directly relating to the treatment of mental illness or in other matters related to the Act and;

(vii) A determination of mental illness shall in no way imply or be taken to mean that the person lacks competence to make his or her decisions.

Section 4: Competence

(i) "Competence" or "competent to make a decision" means the person has ability to:

a) understand the information relevant to the decision and;

b) retain that information and;

c) use or weigh that information as part of the process of making the decision and;

d) communicate his or her decision by any means (by talking, using sign language or any other means)

Explanation : 'Information relevant to a decision' above means information about the consequences of making a decision one way or other and information about the consequences of not making the decision. Such information shall be given to a person in a way and manner (using simple language, in the language the person understands, sign language, visual aids or any other means) that the person is able to understand the information.

(ii) If a person makes a decision which is perceived by others as inappropriate or wrong decision, this shall by itself not be grounds to regard the person as not being competent to make the decision, as long as the person has the ability as mentioned in sub-section (i) above.

(iii) That a person has a mental illness by itself shall not be taken to mean that he or she is not competent to make decisions. All persons with mental illness are regarded as competent to make decisions except when they lack the ability as mentioned in sub-section (i) above.

Section 5 : Advance Directive

(i) Every person has a right to make an 'Advance Directive' in writing, specifying any or all of the

following:

a) the way the person wishes to be cared for and treated for a mental illness and/or;

b) the way the person wishes not to be so cared for and treated for a mental illness and/or;

c) the individual or individuals, in order of precedence, the person wants appointed as their nominated representative under Section 6 below in the event of his or her having a mental illness in the future.

(ii) An Advance Directive may be made by a person whether or not the person has had a mental illness in the past and whether or not the person has received treatment for a mental illness in the past.

(iii) An Advance Directive shall be made in writing on a plain paper with the person's signature or thumb impression on it. The Advance Directive shall also be signed by a medical practitioner certifying that the person is competent at the time of writing the Advance Directive.

(iv) An Advance Directive may be revoked, amended or canceled at any time by the person who made it. The procedure for revoking, amending or canceling an Advance Directive shall be the same as making an Advance directive in sub-section (iii) above. In particular, all revocations, amendments or cancellations should be signed by a medical practitioner certifying that the person is competent and aware of what he is doing, when the Advance Directive is revoked, amended or canceled.

(v) If a person makes an Advance Directive which contains a refusal of all future medical treatment for mental illness, then such an Advance Directive shall not be valid unless it has been submitted to the District Panel of the Mental Health Review Commission (section 22 below) and the District Panel following a hearing, has certified the validity of the Advance Directive.

(vi) Medical officer in charge of a mental health facility and/or the psychiatrist in charge of a person's treatment is duty bound to follow a valid Advance Directive, subject to sub-section (vii) below, when proposing treatment of a person with mental illness.

(vii). If a mental health professional or a relative or a care-giver of the person desires to over-rule a valid Advance Directive when treating a person with mental illness, the mental health professional or the relative or the care-giver of the person, may apply to the District Panel of the Mental Health Review Commission for review and cancellation of the Advance Directive. Upon such application by the mental health professional, relative or care-giver, the District Panel of the Mental Health Review Commission may either uphold, over-rule, modify, or alter the Advance Directive taking into consideration whether :

a) the Advance Directive was made of the person's free will and free of all undue influence and/or;

b) the person intended the Advance Directive to apply to the present circumstances, which may be different from those anticipated and/or;

c) the person was sufficiently well informed to make the decision and/or;

d) the person was competent when the Advanced Directive was made and/or;

e) the Advance Directive is in the best interests of the person concerned and/or;

f) the content of the Advance Directive is contrary to other laws and Constitutional provisions.

(viii) Notwithstanding any provision in this section, it shall not apply to any emergency treatment given under Section 50

(ix) The Mental Health Review Commission shall regularly and periodically review the use of Advance Directives. In it reviews, the Mental Health Review Commission shall give specific consideration to the procedure for making an Advance Directive and whether the existing procedure protects the rights of persons with mental illness. The Mental Health Review Commission may from time to time, make additional regulations with regard to the procedure for Advance Directive to ensure that the rights of persons with mental illness are protected.

(x) A medical practitioner or a psychiatrist shall not be held liable for any unforeseen consequences on following a valid Advance Directive.

Section 6. Nominated Representative

(i) Any person with mental illness who has attained the age of eighteen years has the right to appoint a Nominated Representative, except when the person lacks the competence to make this decision. Such appointment shall be made in writing on plain paper with the person's signature or thumb impression. This document shall be countersigned by a medical practitioner certifying that the person is competent when making the decision to appoint a Nominated Representative.

(ii) In the absence of such an appointment under sub-section (i), the individuals in the order of precedence mentioned below shall be the nominated representative for a person with mental illness.

a) the individual named as the nominated representative in an Advance Directive under Section 5 , subject to Section 5, sub-section (vii), or if none,

b) a relative as defined in Section 2 sub-section (o) above or if none,

c) a care-giver as defined in Section 2 sub-section (a) above excluding a relative, or if none,

d) a person appointed as nominated representative by the District Panel of the Mental Health Review Commission.

iii) In case of persons who do not have a nominated representative under sub-section (i) or (ii) above, any member of the public or a representative of registered organizations working with homeless people or persons with mental illness, may temporarily undertake to perform the duties of a nominated representative and shall be recognized as such under this Act, pending appointment of a nominated representative by the District Panel of the Mental Health Review Commission. The person temporarily undertaking to be the nominated representative shall make a written application to the Medical Officer in charge of the mental health facility and the Medical Officer shall recognize this person as the temporary nominated representative, pending appointment of a nominated representative by the District Panel.

(iv) Notwithstanding sub-sections (i) and (ii) above, the nominated representative for a person with mental illness under the age of eighteen years ("minor") shall be the legal guardian of that person, unless the District Panel of the Mental Health Review Commission orders otherwise under sub-section

(v) below.

(v) Upon application by a mental health professional or any other person acting in the best interest of the minor, and based on evidence presented before it, the District Panel of the Mental Health Review Commission may order that the legal guardian of a person with mental illness under the age of eighteen years ("minor") shall not be the nominated representative of such minor person on the grounds

that either :

(a) the legal guardian is not acting in the best interests of the person; or

(b) the legal guardian is otherwise unsuitable to act as the nominated representative.

(vi) The District Panel of the Mental Health Review Commission at the time of making an order under sub-sections (iii) and (v), shall designate any suitable individual as the nominated representative of the person with mental illness. If no such individual is available for appointment as nominated representative, the Commission shall appoint the Director, Department of Social Welfare, or his designated representative, as the nominated representative for the person with mental illness.

(vii) The person nominated to be representative must be at least eighteen years of age, must be competent to fulfill the role as described in this Act, and must signify, in writing, his or her willingness to perform the role.

(viii) A person who has made an appointment under this section may revoke or alter the appointment at any time, unless he or she is not competent at the time of such revocation or alteration. Such revocation shall be in writing, on plain paper with the person's signature or thumb impression. This document shall be countersigned by a medical practitioner certifying that the person is competent when making the decision to revoke or alter the nominated representative.

(ix) The District Panel of the Mental Health Review Commission may revoke an appointment made under this section, and appoint a different representative under this section when appropriate to do so.

(x) Applications to the District Panel of the Mental Health Review Commission to make, revoke, alter, change, or modify an appointment under this section may be made by the person with mental illness, or by a relative of such person, or by the psychiatrist responsible for the care of such person, or by the medical officer in charge of the mental health facility where the individual is or is proposed to be admitted.

(xi) While fulfilling his or her duties under this Act, the nominated representative shall consider the current and past wishes, the life history, values, cultural background and the best interests of the person with mental illness. The nominated representative shall give particular credence to the views of the person to the extent that person understands the nature of the decisions under consideration.

(xii) The Nominated Representative has the following duties and rights :

a) Duty to support the person with mental illness in making treatment decisions under Sections 45 and 46 .

b) Right to information on diagnosis and treatment in so far as is required for the nominated representative to provide adequate care to the person with mental illness.

c) Right to access family based rehabilitation services as provided in Section 7 on behalf of and for the benefit of the person with mental illness.

d) Right to be involved in discharge planning under Section 54 .

e) Right to apply to the mental health facility for admission under Sections 43, 45 and 46

f) Right to apply to the District Panel of the Mental Health Review Commission on behalf of the person with mental illness for discharge from 43, 45 and 46

g) Right to apply to the District Panel of the Mental Health Review Commission against violation of the rights of the person with mental illness in mental health facilities.

h) Right to give consent for research under circumstances mentioned in Section 55 .

(xiii) The appointment of a nominated representative, or the inability of a person with mental illness to appoint a nominated representative, does not presume or shall not be taken to presume a lack of legal capacity. All persons with mental illness have legal capacity but may require varying levels of support from their nominated representative to make decisions. The level of support required may vary from little support to very high support from time to time.

Chapter II : Rights of Persons with Mental Illness

Section 7 : Right to Access Mental Health Care

(i) All persons have a right to access mental health care and treatment from mental health services run or funded by the Government. The exercise of this right requires such mental health services are affordable, of good quality, available in sufficient quantity, accessible geographically, without discrimination on any basis and provided in a manner that is acceptable to persons with mental illness and their families and care-givers. To enable persons with mental illness to exercise this right, the minimum obligations on the Government are as outlined in this section below.

(ii) Government shall make sufficient provision as may be necessary, for a range of services required by persons with mental illness. These include, but is not limited to, provision of acute mental health care services such as outpatient and inpatient admission facilities, facilities and services for providing long term mental health care for persons with long term mental illness, mental health services to support family based rehabilitation, hospital and community based rehabilitation facilities and services, provision for child mental health services and old age mental health services.

(iii) Mental health services shall be integrated into general health care services at all levels of health care including primary, secondary and tertiary care level of health services and in all health programmes run by the Government. As a minimum provision, a range of appropriate mental health services as described in sub-section (ii) above, shall be available at all general hospitals in every district in the country which are run or funded by the Government and basic and emergency mental health care services shall be available at all Community Health Centers (CHC) run or funded by the Government.

(iv) Mental health services shall provide treatment in a manner which supports persons with mental illness to live in the community and with their families. Long term hospital based mental health treatment shall be used only in exceptional circumstances, for as short a duration as possible, and only as a last resort when appropriate community based treatment has been tried and shown to have failed.

(v) No person with mental illness including children and older persons, shall have to travel long distances to access mental health services. Such services shall be available close to where a person with mental illness normally resides. As a minimum, mental health services run or funded by the Government as described in sub-section (ii) above, shall be available in each district. If the Government fails to maintain minimum mental health services as outlined in sub-section (ii) above, in the district that the person with mental illness normally resides in, the person with mental illness is entitled to access any other mental health service in the district and the costs of treatment at such facilities in that district will be borne by the Government. The Government shall frame rules regarding costs of treatment at such mental health services in this regard.

(vi) A person with mental illness below the poverty line is entitled to treatment free of any charge and

at no financial cost, at all mental health facilities run or funded by the Government and at other mental health facilities designated by the Government.

(vii) Mental health services shall be of equal quality to other general health services and there shall be no discrimination in quality of services provided to persons with mental illness. The minimum quality standards shall be as prescribed by the State Mental Health Authorities.

viii) As a minimum, essential medicines used for the treatment of mental illness as enumerated in the World Health Organisation (WHO) Essential Drug List shall be available free of cost to all persons with mental illness at all times at health facilities run or funded by the Government, starting from community health centres and above in the public health system.

(ix) The Government shall take measures to ensure that necessary budgetary provisions in terms of adequacy, priority, progress, and equity are made for effective implementation of the provisions of this section.

Explanation : In sub-section (ix) above, *Adequacy* means in terms of how much is enough to offset inflation; *Priority* means in terms of compared to other budget heads, *Progress* means in terms of indicating an improvement in the state's response and *Equity* means in terms of fair allocation of resources taking into account the health, social and economic burden of mental illness on individuals, their families and care-givers.

(x) The Central Government shall submit an annual report to the Parliament and the respective State Governments shall submit an annual report to the State Legislature detailing the progress made towards achieving access to mental health care in the country.

Section 8 : Right to Community Living

All persons with mental illness have a right to live in, be part of and not be segregated from society. No person with mental illness shall continue to remain in a mental health facility merely because he or she does not have a family or is not accepted by his or her family or is homeless or because of the absence of community based facilities. The Government shall therefore provide for and/or support the establishment of less restrictive community based facilities including halfway homes, group homes and like, for persons who no longer require treatment in a more

restrictive mental health facility.

Section 9 : Right to Protection from Cruel, Inhuman and Degrading Treatment

(i) All person with mental illness have a right to live with dignity.

(ii) No person with mental illness shall be subjected to any cruel inhuman or degrading treatment in a mental health facility.

(iii) Protection from cruel inhuman and degrading treatment means that all persons have the following minimum rights in mental health facilities:

a) to live in safe and hygienic environment

b) to have adequate sanitary conditions

c) to have facilities for leisure, recreation, education and religious practices

d) Protection of privacy, in particular for women

e) Not to be forced to undertake work in a mental health facility they do not wish to do and appropriate remuneration for work when undertaken.

f) to have adequate provision for preparing the person for living in the community

g) to have adequate provision for food, space, and access to articles of personal hygiene. In particular, women's personal hygiene needs shall be adequately addressed by providing access to items that may be required during menstruation.

h) to not be subject to compulsory tonsuring (shaving of head hair).

i) to wear own personal clothes and not be forced to wear uniforms provided by the facility.

j) to be protected from all physical, emotional and/or sexual abuse

Section 10 : Right to Equality and Non-discrimination

Persons with mental illness shall be treated equal to persons with physical illness in the provision of all health care. This includes but is not restricted to the following :

(i) There shall be no discrimination on any basis including gender, sex, sexual orientation, religion, culture, caste, social or political beliefs, class or disability

(ii) Public and private insurance providers shall make provisions for medical insurance for treatment of mental illness on the same basis as is available for treatment of physical illness.

(iii) Emergency facilities and emergency services for mental illness shall be of the same quantity and quality as those provided to persons with physical illness. Persons with mental health services are entitled to the use of ambulance services in the same manner, extent and quality as provided to persons with physical illness

(iv) Living conditions in health facilities shall be of the same manner, extent and quality as provided to persons with physical illness;

(v) Any other health services provided to persons with physical illness shall be provided in same manner, extent and quality to persons with mental illness.

Section 11 : Right to Information

(i)A person with mental illness and his or her nominated representative shall have the right to know the following :

a) The section of this Act under which he or she is admitted, if he or she is being admitted, and the criteria for admission under that section;

b) Of his or her rights to apply to the District Panel of Mental Health Review Commission for a review of the admission;

c) Of the nature of the person's mental illness and the proposed treatment plan. This includes information about treatment proposed and the known side effects of such proposed treatment.

d) In a language and form that the person receiving the information can understand.

e) In the event that complete information cannot practicably be given to the person with mental illness at the time of the admission or the start of treatment, it is the primary responsibility of the medical officer or psychiatrist in charge of the person's care to ensure that the full information is provided promptly when the individual is in a position to receive it. The nominated representative will nonetheless be given the information immediately.

(ii) The primary responsibility for informing the person with mental illness and his or her nominated representative of the person's medical condition, legal status and rights lies with the medical officer or the psychiatrist in charge of the facility or psychiatrist or medical officer in charge of the individual's care. This task may be delegated by the medical officer or psychiatrist to an appropriate person.

Section 12 : Right to Confidentiality

(i) A person with mental illness has a right to confidentiality in the context of his mental health and

mental health care.

(ii) All health professionals providing care and treatment to a person with mental illness have a duty to keep all such information confidential which has been obtained in the context of care and treatment with the following exceptions :

a) Release of information to the nominated representative to enable him or her to fulfill his or her duties under the Act

b) Release of information to other mental health professionals and other health professionals to enable them to provide care and treatment to the person with mental illness

c) Release of information if it is necessary to protect any other person from harm or violence. Only such information that is necessary to protect against the harm identified may be released.

d) Life threatening emergencies where such information is urgently needed to save lives

e) When ordered by the District Panel of Mental Health Review Commission or the Mental Health Commission or High Court or Supreme Court to do so

f) In the interests of public safety and security

iii) This right to confidentiality also applies to all information stored in electronic and/or digital format in real or virtual space.

Section 13 : Access to Medical Records

(i)All persons with mental illness shall have access to their medical records. The psychiatrist in charge of such records may withhold specific information in the medical records if disclosure would result in :

a) serious mental harm to the person with mental illness and/or

b) likelihood of harm to other persons

(ii) When any information in the medical records is withheld from the person, the psychiatrist shall inform the person with mental illness of his or her right to apply to the District Panel of Mental Health Review Commission for an order to release such information.

Section 14 : Right to Personal Contacts & Communication

(i) A person with mental illness admitted to a mental health facility has the right to receive visitors and to receive and make a reasonable number of telephone/mobile phone calls at reasonable times of the day.

(ii)The medical officer in charge of a mental health facility may prohibit or restrict visits or telephone/mobile phone calls with named individuals, when the visit or telephone/mobile phone call is likely to interfere with the treatment of the person to be visited or cause that person undue distress, or may cause danger to any person. A person whose visits have been restricted under this section may apply to the District Panel of Mental Health Review Commission for an order determining their rights to visit the person with mental illness.

(iii) A person with mental illness admitted in a mental health facility may send and receive mail and email.

(iv) Where an individual (the recipient) informs the medical officer in charge of a mental health facility in writing that he or she does not wish to receive mail or email from a named person in the mental health facility, the medical officer in charge may restrict such communication by the person with mental illness to the recipient.

(v) Where the medical officer in charge of a mental health facility is of the view that mail or email

sent to an individual (recipient) by a person with mental illness admitted in the mental health facility is sent

for an illegal purpose or would cause undue distress to the person to whom it is addressed, or would cause danger to any person, the medical officer in charge may restrict such communication and make a record of the same in the medical notes. Any person whose mail or email is so restricted may apply to the District Panel of Mental Health Review Commission for a review of this decision.

(vi) Visits from, telephone calls to and from and mail or email to and from individuals listed below cannot be restricted under any circumstances. Sub-section (ii) and (v) shall not apply to visits, telephone calls, mail or email from

a) any Court or Judicial Officer

b) the District Panel, the Mental Health Review Commission or the State Mental Health Authority

c) any member of the Parliament or State Assembly

d) Nominated representative, lawyer or legal representative of the person

Section 15 : Right to Legal Aid

The person with mental illness shall be entitled to receive free legal services to exercise any of his or her rights given under this Act. It shall be the duty of medical officer in charge of a mental health facility or psychiatrist in charge of the person's mental health care to inform the person with mental illness that he or she is entitled to free legal services under the Legal Services Authorities Act, 1987 and provide the contact details of the availability of services.

Section 16 : Right to make Complaints about Deficiencies in Provision of Services

(i) Any person with mental illness and their nominated representative, has the right to complain regarding deficiencies in provision of care, services in the mental health facility to

a) the medical officer in charge of the facility and if they are not satisfied with the response,

b) to the State Mental Health Authority and if the are not satisfied with the response,

c) to the District Panel of the Mental Health Review Commission

(ii) The complaints provisions in sub-section (i) above, is without prejudice to the rights of the person to seek any judicial remedy for violation of their rights in a mental health facility or by an mental health professional either under this Act or any other Act.

Chapter III : Duties of Government

Section 17: Promotion of Mental Health & Preventive Programmes

The Government shall have a duty to plan, design and implement programs for the promotion of mental health and prevention of mental illness in the country.

Section 18: Creating Awareness about Mental Health and Illness and Reducing Stigma associated with Mental Illness

The Government shall take all measures to ensure that :

(i) the provisions of this Act are given wide publicity through public media, including television, radio, print and online media at regular intervals

(ii) programs to reduce stigma associated with mental illness are planned, designed, funded and implemented

(iii) Government officials including police officers, members of the judicial services are given periodic sensitization and awareness training on the issues addressed by this Act.

Section 19 : Human Resources and Training

(i)Recognizing that access to mental health care and the rights of persons with mental illness cannot be guaranteed without availability of sufficient numbers of trained health professionals, the Government shall take all necessary measures to address the human resource requirements of mental health services in the country by planning, developing and implementing educational and training programs in collaboration with institutions of higher education and training, to in-

crease the human resources available to deliver mental health interventions and to improve the skills of the available human resources to better address the needs of persons with mental illness.

(ii) The Government shall, at the minimum, train all medical officers in public health care facilities and all medical officers in the prisons or jails to provide basic and emergency mental health care.

(iii) The Government shall also make all efforts to meet the internationally accepted recommendations for number of mental health professionals on the basis of population, within ten years from the date of notification of this Act. Information about progress made in improving the human resource situation shall be included in the annual reports to be submitted by the Central and State Governments under Section 7 sub-section (x).

Section 20: Co-ordination within the Government

The Government shall take all measures to ensure effective co-ordination between the services provided by concerned Ministries and Departments such as those dealing with law, home affairs, human resources, and social welfare to address issues of mental health care.

Chapter IV : Mental Health Review Commission

Section 21 : Constitution of a Mental Health Review Commission

(i)The Central Government shall constitute the Mental Health Review Commission within 3 months of the Act coming into force to exercise the powers conferred upon and to perform the functions assigned to it under this Act.

(ii) The Commission shall have jurisdiction all over the country and it shall have its headquarters in .....

(iii) The Commission shall consist of

a) A President who has been or is qualified to be appointed as Judge of the High Court and;

b) One member who is a Psychiatrist with at least 15 years experience and;

c) One member who is a representative of persons with mental illness, or families and caregivers to persons with mental illness or non-governmental organizations working in the field of mental health.

(iv) The President and Members of the Commission shall be appointed by the President of India on the recommendation of the Central Government. The recommendation for appointment of the President of the Commission shall be made by the Central Government in consultation with the Chief Justice of the Supreme Court. The recommendation for appointment of Members shall be made by the Central Government following a public advertisement.

(v) The President of the Commission may appoint administrative officers and such other employees as may be necessary. The salary and allowances payable to and the other conditions of service of the 18 | Page

administrative officers and other employees of the Commission appointed under this section shall be such as may be determined by Central Government.

Section 22 : Constitution of District Panels of the Mental Health Review Commission

(i) The Commission shall appoint and function through the District Panels which shall be based in thedistricts. The functions, powers and authority of the Commission shall be exercised by the District Panels of the Commission. The jurisdiction of a particular District Panel shall be as prescribed by the Commission. The District Panels shall receive guidance from the Commission on the interpretation of the Act and the procedures to be followed.

(ii) Each District Panel of the Commission shall consist of

a) A Chairperson who has been or is qualified to be appointed as a District Judge.

b) Two members who shall be mental health professionals of whom one shall be a psychiatrist. If a psychiatrist is not available to serve on the Panel, both members can be mental health professionals other than psychiatrists.

c) Two members who shall be persons with mental illness or care-givers or persons representing organizations of persons with mental illness or care-givers or non-governmental organizations working in the field of mental health.

(iii) The President of the Commission shall constitute a Committee for each State to appoint members of the District Panels for the districts in that State. This Committee shall also decide the number of District Panels needed in the State depending on the expected or actual workload of the Panel(s) in that State, and in as many Districts of the country taking into account the presence of mental health facilities in the district and the convenience of persons with mental illness, their families and the professionals involved in providing care in mental health facilities in the district. The Committee shall consist of

a) the President or one of the Members of the Commission (the Chairperson)

b)Chief Justice (or a person nominated by the Chief Justice) of the High Court of the State

c) Secretary (or a person nominated by the Secretary) of Ministry of Law of the State

d) Secretary (or a person nominated by the Secretary) of Ministry of Health and Family Welfare of the State

e) Secretary (or a person nominated by the Secretary) of Ministry of Social Welfare of the State

Section 23: Disqualification & Removal

(i) A person shall be disqualified to serve as President or Member of the Commission or be removed by the President of India on the recommendation of the Central Government if he or she

a) has been convicted and sentenced to imprisonment for an offence which involves moral turpitude or ;

b) is adjudged as insolvent; or

c) has been removed or dismissed from the service of the Government or a body corporate owned or controlled by the Government; or

d) has such financial or other interest as is likely to prejudice the discharge by him or her functions as a member; or

e) has such other disqualifications as may be prescribed by the Government;

(ii) A person shall be disqualified to serve as Chairperson or Member of the District Panel or be removed by the Mental Health Review Commission if he or she

a) has been convicted and sentenced to imprisonment for an offence which involves moral

19 | Page

turpitude or;

b) is adjudged as insolvent; or

c) has been removed or dismissed from the service of the Government or a body corporate owned or controlled by the Government; or

d) has such financial or other interest as is likely to prejudice the discharge by him or her functions as a member; or

e) has such other disqualifications as may be prescribed by the Government;

(iii) The President of the Commission may resign his office in writing addressed to the President of India, while a Member of the Commission may resign his or her office in writing addressed to the President of the Commission and on such resignation being accepted, the vacancy shall be filled by appointment of a person, belonging to the category under Section 21 sub-section (iii) above, of the person who has resigned.

iv) A Chairperson or Member of the District Panel may resign his or her office in writing addressed to the President of the Commission and on such resignation being accepted, the vacancy shall be filled by appointment of a person, belonging to the category under Section 22 sub-section (ii) above, of the person who has resigned.

Section 24: Terms and Conditions of Service

(i) The President, Members of the Commission, Chairperson and Members of the District Panels of the Commission shall hold office for a term of five years or up to the age of seventy years, whichever is earlier. The President, Members and Chairperson shall be eligible for re-appointment for another term of five years or up to the age of seventy years whichever is earlier.

(ii) The President of the Commission shall be a full time appointment. The appointment of Members of the Commission and Chairperson and Members of the District Panels on a full-time or part

time basis shall be made by the President of the Commission taking into consideration the work load of the Commission and the Panels.

(iii) The salary or honorarium and other allowances payable to, and the other terms and conditions of service of the President, Members of the Commission and Chairperson and Members of the District Panels shall be such as may be prescribed by the Central Government.

Section 25 : Decisions of the Commission and the District Panels

The decisions of the Commission and the District Panels shall be based on the opinion of the majority present.

Section 26 : Applications to District Panel

(i) Any person with mental illness whose rights under this Act are violated, or a nominated representative on his or her behalf, or a representative of a registered non-governmental organization with the consent of such a person, may make an application to the District Panel seeking redressal.

(ii) There shall be no fee or charge levied for making such an application.

(iii) Every application shall contain the name of applicant, his or her contact details, the details of the violation of his or her rights, the mental health facility where such violation took place and the redressal sought from the District Panel. In exceptional circumstances, the District Panel shall accept an application made verbally over telephone from a person admitted to a mental health facility.

Section 27 : Proceedings before the District Panel

(i) All proceedings before a District Panel of the Commission shall be deemed to be a judicial proceeding within the meaning of Section.....of the Civil Procedure Code and the District Panel shall be deemed to be a civil court for the purposes of the Act. The District Panel may evolve its own procedure to hear the proceedings.

(ii) Any matter before the District Panel shall be heard as expeditiously as possible. An endeavor shall be made to dispose of applications for appointment of nominated representative under Section 6, applications challenging admissions of a minor under Section 43 and applications challenging supported admission under Section 45 within a period of 7 days from the filing of such applications, and applications challenging supported admission under Section 46 within a period of 21 days from date of filing of the application. With respect to all other applications under other sections of the Act, an endeavor shall be made to finally dispose of the application within a period of ninety days from the date of filing of the application.

(iii) The District Panel shall endeavor to complete the mandatory review under Section 43 within a period of 7 days and under Section 46 within a period of 21 days from time it is due.

(iv) The District Panel shall not ordinarily grant adjournment for the hearing.

(v) The parties to the hearing shall be the person with mental illness, his or her nominated representative, and the medical officer in charge of the mental health facility or the psychiatrist responsible for the care of the person as the case may be. The parties may be represented by a counsel or another representative of their choice, or may appear in person.

(vi) The hearing shall not be open to the public. Persons other than those directly involved may be admitted with the permission of both the person with mental illness and the Chairperson of the District Panel.

(vii) The person with mental illness about whom the hearing relates shall have the right to give oral evidence to the District Panel, if he or she wishes to do so. The District Panel shall have the power to require the attendance and testimony of such other witnesses as it deems appropriate under the circumstances.

(viii) All parties shall have the right to see any document relied on by any other party in its submissions to the District Panel.

(ix) The decision of the District Panel shall be communicated to the parties in writing within five days of the completion of the hearing.

(x) Any member who is directly or indirectly involved in a particular case, shall not sit on the District Panel during the hearings with respect to that case.

Section 28: Functions of the Mental Health Review Commission and District Panel of the Mental Health Review Commission

(i) The Mental Health Review Commission shall have the following functions

a) Appoint and remove members of the District Panels under Section 22

b) Give guidance to the District Panel on interpretation of the Act and the procedures to be followed

c) Periodically review the use of Advance Directives and make additional regulations with regard to the procedure for Advance Directive

d) Advise the Central Government on matters relating to the promotion and protection of rights of persons with mental illness

(ii) The District Panel of the Mental Health Review Commission shall have the following functions

a) To review, alter, modify an Advance Directive as provided for in Section 5

b) To appoint a nominated representative as provided in Section 6

b) To decide applications under Sections 16, 26, 43, 45 and 46

c) To decide applications regarding non-disclosure of information as provided in Section 13

d) To decide complaints regarding deficiencies in care and services as provided in Section 16

e) To visit prison or jails and question the responsible medical officer as mentioned in Section 59

(iii) Where it is brought to the notice of a District Panel of the Mental Health Review Commission or to the Commission itself, that a mental health facility is violating the rights of persons with mental illness, the District Panel or the Commission itself shall direct the State Mental Health Authority to conduct an inspection and inquiry and submit a report of such inspection and inquiry to the District Panel and the Mental Health Review Commission and the action taken or proposed to be taken by the State Mental Health Authority to protect the rights of persons with mental illness in the mental health facility. Notwithstanding anything else in the Act, the District Panel in consultation with the Commission may take any action to protect the rights of persons with mental illness as it deems appropriate, including closing down the mental health facility.

(iv) If it is found that a mental health facility is willfully neglecting the order of the District Panel, the Panel may punish the mental health facility with an exemplary fine and as a matter of last resort, order the State Mental Health Authority to cancel the registration of the mental health facility.

Section 29 : Appeals

Any person or facility aggrieved by the decision of the Commission or a District Panel may appeal to the High Court of the State in which the District Panel is located or where the person or the facility is located, within 30 days of the decision.

Section 30 : Budgetary Provisions for the Commission and District Panels

The Central Government shall make sufficient budgetary provisions for the effective functioning of the Mental Health Review Commission and the District Panels.

Section 31 : Power to make regulations

The Central Government may, from time to time, make Regulations for the purpose of carrying out the provisions of this section.

Chapter V: State Mental Health Authority

Section 32 : State Mental Health Authority

(i) The State Government shall establish the State Mental Health Authority (hereinafter referred to as the Authority) within 3 months of the Act coming into force.

(ii)The Authority established under sub-section (i) shall be subject to the superintendence, direction and control of the State Government.

Section 33 : Composition of the State Mental Health Authority

(i) The State Government shall constitute the State Mental Health Authority within 3 months of the Act coming into force to exercise the powers conferred upon, and to perform the functions assigned to it under this Act.

(ii) The Authority shall compose of the following members :

a) Ex-Officio Members who shall be

1) Secretary or Principal Secretary, State Department of Health

2) Representative of State Department of Health responsible for mental health.

3) Superintendent of any of the Mental Hospitals in the State or Head of Department of Psychiatry at any Government Medical College.

b) Other Members :

a) A prominent psychiatrist from the state not in government service

b) A registered Psychiatric Social Worker

c) A registered Clinical Psychologist

d) A registered Mental Health Nurse

e) Two persons representing persons who have or have had mental illness

f) Two persons representing care-givers of persons with mental illness and/or organizations representing such care-givers

g) Two persons representing non-governmental organizations providing services to persons with mental illness or doing advocacy work in the field of mental health.

(iii) The Members referred to in sub-section (ii) (b) above, shall be appointed by the State Government following a public advertisement.

(iv) Every ex-officio member shall hold office as such member so long as he or she holds the office by virtue of which he or she was appointed.

(v) Every member (not an ex-officio member) shall hold office for a period of three years from the date of his or her appointment and shall be eligible for re-appointment.

(vi) A member (not an ex-officio member) may at any time resign from membership of the Authority by forwarding his or her letter of resignation to the Chairperson and such resignation shall take effect only from the date on which it is accepted.

(vii) Where a vacancy occurs by resignation of a member (not an ex- officio member) the State Government shall fill the vacancy by appointing from amongst category of persons referred to in subsection (ii) (b) above.

(viii) Where the term of office of any member (not an ex-officio member) is about to expire the State Government may appoint a successor at any time within three months before the expiry of the term of such member but the successor shall not assume office until the term of the outgoing member expires.

Section 34 : Chairperson and Executive Officer of the State Mental Health Authority

(i) The Secretary, State Department of Health or Principal Secretary State Department of Health shall be the Chairperson of the Authority.

(ii) The Chairperson shall appoint an Executive Officer to the Authority. The Authority shall draw up the skills requirements for the post of Executive Officer, the terms and conditions of service for this post and appoint a person to this post after advertisement and interview.

(iii) The Executive Officer shall be a full-time employee of the Authority. The Executive Officer shall be responsible for the day to day functioning of the Authority, the control and management of office accounts and correspondence. The Executive Officer shall cause to be appointed such members of the ministerial and non-ministerial staff which are essential for the efficient functioning of the Authority. The Executive Officer shall exercise such other powers and discharge such other functions as may be authorized in writing by the Chairperson for the efficient functioning of the Authority.

Section 35 : Functions of the State Mental Health Authority

The Authority shall

(i) register all mental health facilities in the State under Section 39 and maintain and publish (including online on the internet) a register of such facilities.

(ii) develop quality and service provision norms for different types of mental health facilities in the state

(iii) supervise all mental health facilities in the State

(iv) make rules and regulations for the registration of clinical psychologists, mental health nurses and psychiatric social workers in the State to work as mental health professionals for the purpose of this Act and publish the list (including online on the internet) of such registered mental health professionals.

(v) train all relevant persons including judicial officers, law enforcement officials, mental health professionals and other health professionals about the provisions and implementation of this Act.

(vi) advise the State Government on all matters relating to mental health care and services.

(vii) submit an Annual Report to the State Legislature in June of each calendar year, alongwith a review of the progress of implementation of the various provisions of Mental Health Act during the preceding one year. The Authority shall also publish this Annual Report in the public domain, including online on the internet, within a month of the report being submitted to the State Legislature.

(viii) discharge such other functions with respect to matters relating to mental health as the State Government may decide.

Section 36 : Proceedings of the State Mental Health Authority

(i) The Authority shall ordinarily meet once every 3 months at such time and place as may be fixed by the Chairperson. Provided that the Chairperson shall

a) call a special meeting at any time to deal with any urgent matter requiring the attention of the Authority.

b) call a special meeting if he receives a requisition in writing signed by not less than four members and stating the purpose for which they desire the meeting to be called.

(ii) The Chairperson or in his absence any member authorized by him shall preside at the meetings of the Authority.

(iii) The quorum for the meeting of the Authority shall be seven members. If within half an hour from time appointed for holding a meeting of the Authority quorum is not present, the meeting shall be adjourned to the same day in the following week at the same time and place and the presiding officer of such meeting shall inform the members present and send notice to other members.

(iv) If at the adjourned meeting also, quorum is not present within half an hour from the time appointed

for holding the meeting, the members present shall constitute the quorum.

(v) In the adjourned meeting if the Chairperson is not present and no member has been authorised to preside at such meeting, the members present shall elect a member to preside at the meeting.

vi) Each member including the Chairperson shall have one vote. In the case of an equality of votes, the Chairperson or any member presiding over such meeting shall in addition, have a casting vote.

vii) All decisions of the meeting of the Authority shall be taken by a majority of the members present and voting.

viii) Any business which may be necessary for the Authority to transact may be circulated and approved by a majority of members, shall be valid and binding as if such resolution had been passed at the meeting of the Authority.

Section 37 : Budgetary provisions

The State Government shall make adequate budgetary provisions for the functioning of the Authority, in particular, grants of such sums of money as are required to pay allowances payable to the Chairperson and the members and the administrative expenses including the salaries, allowances and pension payable to or in respect of officers and other employees of the Authority.

Section 38 : Power to make Regulations

i) The State Government may, by notification in the Official Gazette, make regulations for the function of the Authority

ii) Regulations may provide for

a) the term of office and other conditions of service of the members

b) the powers and duties of the Chairperson and of the members;

c) the form in which and the time within which the Authority shall prepare its budget and its annual report ;

d) the manner in which the accounts of the Authority shall be maintained and audited

Chapter VI: Mental Health Facilities

Section 39 : Registration and Standards for mental health facilities

(i) The State Mental Health Authority shall compile, update and publish (including online) a register of mental health facilities in the State.

(ii) No person or organization shall establish or run a mental health facility unless it has been registered with the State Mental Health Authority under the provisions of this Act. In case a mental health facility has been registered under the Clinical Establishments Act, then a copy of the said registration shall be submitted by the mental health facility to the State Mental Health Authority along with an undertaking that the mental health facility fulfills the minimum standards prescribed by the State Mental Health Authority for the specific category of mental health facility. On submission of the above, mental health facility shall be deemed to be registered under this section of this Act

(iii) For registration and continuation of registration, every mental health facility shall fulfill :

a) the minimum standards of facilities and services as may be prescribed ;

b) the minimum qualifications for the personnel as may be prescribed ;

c) provisions for maintenance of records and reporting as may be prescribed ;

d) and any other conditions as may be prescribed.

(iv) Categories and standards

a) Mental Health facilities shall be classified into such categories, as may be prescribed by the State Mental Health Authority from time to time.

b) Different standards may be prescribed for classification of different categories

c) In prescribing the standards for mental health facilities, the State Mental Health Authority shall have regard to local conditions.

d) Notwithstanding anything in this section, the State Mental Health Authority shall publish standards for different categories of mental health facilities within a period of 15 months from the date of coming into force of this Act.

Section 40 : Procedure for Registration and Inspection of Mental Health Facilities

(i) For the purpose of registration of the mental health facility, an application in the prescribed proforma accompanied by such details as may be prescribed, along with the prescribed fee shall be furnished to the State Mental Health Authority

(ii) The application may be furnished in person or by post or online.

(iii) If any mental health facility is in existence at the time of amendment to this Act coming into force, an application for its provisional registration shall be made within one year from the date of the Act coming into force.

(iv) The Authority shall within a period of ten days from the date of receipt of such application, grant to the applicant a certificate of provisional registration in such form and containing such

particulars and information as may be prescribed ;

(v) The Authority shall not be required to conduct any inquiry prior to grant of provisional registration.

(vi) The Authority shall within a period of 45 days from the grant of the provisional registration, cause to be published, in print and in digital form online, all particulars of the mental health facility to be registered.

(vii) Every provisional registration shall be valid for a period of 12 months from the date of issue of the certificate and such registration shall be renewable.

(viii) Where standards for particular categories of mental health facilities have been notified by the State Government, under Section 39 sub-section (iv) above, the mental health facilities in that category will have to apply for and obtain permanent registration within a period of 6 months from notification of these standards. The Authority shall publish these standards in print and online in digital format.

(ix) Where standards for particular categories of mental health facilities have not yet been notified by the State Government, under Section 39 sub-section (iv) above, the mental health facilities in those categories may apply for a renewal of provisional registration 30 days before the expiry of the validity of certificate of provisional registration. If the application is made after the expiry of provisional registration, the Authority shall allow renewal of registration on payment of such enhanced fees, as

may be prescribed.

(x) Application for permanent registration by a mental health facility shall be made to the Authority in such form and be accompanied by such fees, as may be prescribed.

(xi) The mental health facility shall submit evidence that the facility has complied with the prescribed minimum standards in a manner as prescribed by the Authority

(xii) As soon as the mental health facility submits the required evidence of the mental health facility having complied with the prescribed minimum standards, the Authority shall display this information publicly for filing objections, if any, in a manner prescribed by the Authority, all the evidence submitted by the mental health facility for a period of 30 days before processing for grant of permanent registration. Such information shall at the minimum be displayed on the website to be maintained by the Authority for this purpose.

(xiii) If objections are received within the period referred to in sub-section (xii) above, such objections shall be communicated to the mental health facility for response within a period as prescribed by the Authority.

(xiv) Permanent registration shall be granted only when a mental health facility fulfills the prescribed standards for registration by the State Mental Health Authority.

(xv) The Authority shall pass an order within a period of 30 days after expiry of the prescribed period, either

a) allowing the application for permanent registration or

b) disallowing the application

Provided that the Authority shall record its reasons, if it disallows an application for permanent registration. The Authority may also grant a period of time, not exceeding a period of 6 months to the mental health facility for rectification of the deficiencies which have led to disallowing the application.

(xvi) Notwithstanding anything said above, if the Authority has not communicated any objections received by the Authority to the mental health facility under sub-section (xiii), nor has the Authority passed an order under sub-section (xv) above, within a period of 90 working days from the date of application for permanent registration by the mental health facility, it will be deemed that the Authority has allowed the application for permanent registration.

(xvii) The Authority shall issue a certificate of permanent registration in such form and containing such particulars as it may prescribe, if the Authority has allowed an application under sub-

section (xv) or sub-section (xvi) above.

(xviii) Every permanent registration shall be valid for a period of 36 months from the date of issue of the certificate and such registration shall be renewable. The mental health facility may apply for a renewal of permanent registration 90 days before the expiry of the validity of certificate of provisional registration.

(xix) the disallowing of an application for permanent registration shall not debar a mental health facility from applying afresh for permanent registration under sub-section (x) above and after providing

such evidence of having rectified the deficiencies on which grounds the earlier application was disallowed.

(xx) If at any time after the mental health facility has been registered, the Authority may issue a show cause notice to the mental health facility as to why its registration under this Act should not be canceled if it is satisfied that :

a) the conditions of the registration are not being complied with ; or

b) the person or persons or entities entrusted with the management of the mental health facility have been convicted of an offence under this Act; or

c) the mental health facility is found to be persistently violating the rights of persons with mental illness

(xxi) If after giving a reasonable opportunity to the mental health facility under sub-section (xx) above, the Authority is satisfied that there has been a breach of any of the provisions of conditions for

registration or any Rules made under this Act, the Authority may without prejudice to any other action that it may take against the mental health facility, cancel its registration. Where the Authority is satisfied that the mental health facility is persistently violating the rights of persons with mental illness and where the mental health facility does not, within a reasonable, time, take action to the satisfaction of the Authority to protect the rights of persons with mental illness, the Authority may without prejudice to any other action it may take against the facility, cancel its registration. Every order made under this sub-section shall take effect

a) where no appeal has been made against such order, immediately on the expiry of the period prescribed for such appeal and ;

b) where such appeal has been preferred against such an order and the appeal has been dismissed from the date of the order of dismissal. The Authority after cancellation of the registration for reasons to be recorded in writing, may restrain immediately the mental health facility from carrying on if there is imminent danger to the health and safety of the persons admitted in the mental health facility.

(xxii) The Authority may cancel the registration of a mental health facility if asked by the Mental Health Review Commission or the District Panel of the Commission to do so.

(xxiii) Inspection and Inquiry

a) The Authority shall have the right to cause an inspection of, or inquiry in respect of any mental health facility, to be made by such person or persons as it may direct and that mental health facility shall be entitled to be represented at such an inspection or inquiry.

b) The Authority shall communicate to the mental health facility the view of the Authority with reference to the results of such inspection or inquiry and may after ascertaining the opinion of the mental health facility, advice the facility upon the action to be taken.

c) The mental health facility shall report to the Authority the action which is proposed to be taken or has been taken upon the results of such inspection or inquiry and such report shall be furnished within such time as the Authority may direct.

d) Where the mental health facility does not, within a reasonable time, take action to the satisfaction of the Authority, it may, after consideration any explanations furnished or representation made by the mental health facility issue such directions as the Authority may deem fit, and the

mental health facility shall comply with such directions.

(xxiv) The Authority or any person authorized by the Authority, may, if there is any reason to suspect that anyone is running a mental health facility without registration, enter and search in the manner prescribed by the Authority, at any reasonable time and the mental health facility shall co-operate with such inspection or inquiry and be entitled to be represented at such inspection or inquiry.

(xxv) Any mental health facility or person, aggrieved by an order of the Authority refusing to grant or renew a certificate of registration or revoking a certificate of registration may appeal to the High Court in the State.

Section 41 : Certificates, Fees and Register of mental health facilities

(i) Every mental health facility shall display the certificate of registration in a conspicuous place in the mental health facility in such manner so as to be visible to everyone visiting the mental health facility

(ii) In case the certificate is destroyed, lost, mutilated or damaged the Authority may issue a duplicate certificate on the request of the mental health facility and on the payment of such fees as may be prescribed

(iii) The certificate of registration shall be non-transferable and in event of change of category the certificate shall be surrendered to the Authority and the mental health facility shall apply afresh for grant of certificate of registration.

(iv) The Authority may charge fees for different categories of mental health facilities, as may be prescribed.

(v) The Authority shall maintain in digital format a register of mental health facilities, registered by the Authority, to be called the State Register of Mental Health Facilities and shall enter the particulars of the certificate so issued in a register to be maintained in such form and manner as may be prescribed.

Chapter VII : Admission, Treatment and Discharge

Section 42 : Independent (without Support) Admission and Treatment

An Independent patient or an Independent admission (without Support) refers to the admission of person to a mental health facility who is competent to make decisions or require minimal support in making decisions. As far as possible, all admissions to mental health facilities should be Independent admissions except when such conditions exist as make supported admission unavoidable.

i) Any person who is not a minor and who considers himself to have a mental illness and desires to be admitted to any mental health facility for treatment may request the medical officer or psychiatrist in charge of the facility to be admitted as a Independent patient.

ii) On receipt of such a request under sub-section (i) the medical officer or psychiatrist in charge of the facility will admit the person to the facility if he is satisfied that

(a) the person has a mental illness of a severity requiring admission to a mental health facility

(b) the person with mental illness will benefit from admission and treatment to the mental health facility

(c) the person has understood the nature and purpose of admission to the mental health facility, has made the request for admission of his own free will, without any duress or undue influence and is

competent to make decisions without support or requires minimal support from others in making such decisions.

(iii) Every person independently admitted to a mental health facility shall be bound to abide by such rules and regulations of the mental health facility.

(iv) An Independent patient shall not be given treatment without his or her informed consent. If a

person is unable to understand the purpose, nature, likely effects of proposed treatment and of the probable result of not accepting the treatment and/or requires a very high level of support approaching 100% support in making decisions, he or she shall be deemed unable to understand the purpose of the admission under sub-section (ii) and therefore shall not be admitted under this section.

(v) Subject to Section 44 sub-section (iii) below, an Independent patient may discharge himself from the mental health facility without the consent of the medical officer in charge of the facility. The medical officer in charge of the facility shall ensure that the individual is informed of this right at the time of admission.

(vi) A person admitted under this section may appoint a nominated representative under Section 6 .

(vii) The mental health facility shall admit an independent patient on his own request, and shall not require the consent or presence of a nominated representative or a relative or care-giver for admitting the person to the mental health facility.

Section 43 : Admission of a Minor

Any person under the age of eighteen years (minor) may be admitted to a mental health facility only in exceptional circumstances and following the procedure as laid down in this section.

i) The nominated representative for the minor as defined in Section 6 , shall apply to the medical officer in charge of a mental health facility for admission of the minor to the facility.

ii) Upon receipt of such an application, the medical officer in charge of the mental health facility may admit such a minor to the facility, if two psychiatrists, or one psychiatrist and one mental health professional or one psychiatrist and one medical practitioner, have independently examined the minor on the day of admission or in the preceding 7 days and both conclude based on the examination and, if appropriate, on information provided by others, that :

(a) the minor has a mental illness of a severity warranting admission to a mental health facility and;

(b) admission is in the best interests of the minor, with regard to his or her health, well-being or safety, taking into account the wishes of the minor if ascertainable, and the cultural, religious and social background of the person, and the reasons for reaching this decision and;

(c) the mental health care needs of the minor cannot be met unless he or she is admitted as proposed and in particular, all community based alternatives to admission have been shown to have failed or are demonstrably unsuitable for the needs of the minor.

iii) Any person under the age of eighteen years so admitted shall be accommodated separately from adults, in an environment that takes into account his or her age and developmental needs and is of the same level of quality as is provided to other persons of their age admitted to hospitals for medical conditions. The nominated representative or an attendant appointed by the nominated representative

shall under all circumstances stay with the minor in the mental health facility for the entire duration of the admission of the minor to the mental health facility. In the case of minor girls, where the nominated representative is male, a female attendant shall be appointed by the nominated representative and shall under all circumstances stay with the minor girl in the mental health facility for the entire duration of her admission.

iv) A minor shall be given treatment with the informed consent of his or her nominated representative.

v) If the nominated representative no longer supports admission of the minor under this section or requests discharge of the minor from the mental health facility, the minor shall be discharged by the mental health facility.

vi) Any admission of a minor to a mental health facility shall be informed to the District Panel of the Mental Health Review Commission within a period of 72 hours by the mental health facility. The District Panel shall have the right to visit and interview the minor or review the medical

records if the District Panel desires to do so. Any admission of a minor which continues for a period of 30 days or more shall be informed to the District Panel of the Mental Health Review Commission. The District Panel shall carry out a mandatory review within a period of 7 days of it becoming due, of all admissions of minors continuing beyond 30 days and every subsequent 30 days. For this mandatory review, the District Panel shall at minimum, review of the clinical records of the minor. The District Panel may interview the minor if it deems necessary.

Section 44 : Discharge of Independent Patients

(i) The medical officer in charge of a mental health facility shall discharge from the mental health facility any person admitted under Section 42 immediately on request made by such a person or if the person disagrees with his or her admission under Section 42 , subject to sub-section (iii) below.

(ii) Where a minor has been admitted to a mental health facility under Section 43 , and is now no longer a minor (i.e. completes eighteen years of age), the medical officer in charge of the mental health facility will classify him/her as a Independent patient under Section 42 and all provisions of the Act as applicable to persons who are not minors will apply ;

(iii) Not withstanding anything else contained in the Act, a mental health professional may prevent discharge of a person admitted under Section 42 and now seeking discharge, for a period of 24 hours, to allow assessment necessary for admission under Section 45, if the conditions below are met :

(a) The mental health professional is of the opinion that the person cannot understand the nature and purpose of their decisions and require substantial or very high support from their nominated representative and ;

(b) either one or all of the following

(1) has recently threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself and/or

(2) has recently behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; and/or

(3) has recently shown or is showing a lack of competence to care for himself or herself to a degree that places the individual at risk of harm to himself or herself;

At the end of the period of 24 hours or earlier if the necessary assessments have been completed, the person can no longer be kept admitted in the mental health facility under this section of the Act.

Section 45: Admission and treatment of persons with mental illness, with high support needs, in a mental health facility, upto 30 days (Supported Admission)

i) The medical officer in charge of a mental health facility shall admit a person to the facility, upon application by the nominated representative of the person, under this section if :

(a) The person has been independently examined on the day of admission or in the preceding 7 days by one psychiatrist and the other being a mental health professional or a medical practitioner, and both conclude based on the examination and, if appropriate, on information provided by others, that the person has a mental illness of such severity that the person :

(1) has recently threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself and/or ;

(2) has recently behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; and/or

(3) has recently shown or is showing a lack of competence to care for himself or herself to a degree that places the individual at risk of harm to himself or herself; and

(b) the mental health professionals and/or the medical practitioner as the case may be, certify that admission to the mental health facility is the least restrictive care option possible in the circumstances ; and

(c) the person is ineligible to receive care and treatment as a independent patient because the person is not competent to make decisions independently and needs very high support from his

or her nominated representative, in making decisions.

(ii) Admission of a person with mental illness to a mental health facility under this section shall be limited to a period of 30 days. At the end of this period, or earlier, if the person no longer meets the criteria for admission as stated in sub-section (i) above, the patient shall no longer remain in the facility under this section. However, at the end of the 30 days, if the conditions under Section 46 are met, the person may continue to remain admitted in the mental health facility in accordance with the provisions of Section 46 below. If the conditions under Section 46 are not met, the person may continue to remain in the mental health facility as a independent patient under Section 42, and the medical officer in charge of the facility shall ensure that the person is told of his or her new status, including his or her right to leave the facility.

(iii) Treatment shall only be provided taking into account an existing Advance Directive as per Section 5 , if any, or if the person with the support of his nominated representative, has given his informed

consent to the treatment plan; the person may require a very high level of support from the nominated representative, approaching 100 % support, where the nominated representative temporarily consents to treatment on behalf of the patient. In all instances where the level of support required is of such high degree that the nominated representative has temporarily consented to treatment on behalf of the person, the medical officer in charge of the facility shall record this in the notes and this shall be

reviewed every 7 days.

(iv) All admissions under this section shall be informed to the District Panel of the Mental Health Review Commission by the mental health facility within 7 days from the date of admission, however this period shall be 3 days in case of a woman admitted to the mental health facility. The District Panel shall have the right to visit and interview the person or review the medical records if it desires so.

(v) A person admitted under this section, or his or her nominated representative on his or her behalf or a representative of a registered non-governmental organization with the consent of the person, may apply to the District Panel of the Mental Health Review Commission for review of the decision to admit him or her to the mental health facility under this section and the decision of the District Panel of the Mental Health Review Commission shall be binding on all parties and the decision shall be made in 7 days from the date of filing the application.

All mental health facilities shall prominently display within the facility, the contact details including address and telephone numbers of the District Panel of the Mental Health Review Commission. The mental health facility shall provide the person with necessary forms to apply to the District Panel of the Mental Health Review Commission and also give free access to make telephone calls to the District Panel to apply for a review of the admission. In exceptional circumstances, the District Panel shall accept an application for review from a person admitted to a mental health facility, verbally over the telephone.

(vi) Notwithstanding anything else in this Act, the medical officer in charge of the facility is under a duty to keep the condition of the person under ongoing review. If the medical officer in charge of the facility becomes aware that the conditions in sub-section (i) are no longer met, the medical officer in charge will terminate the admission under this section, and inform the person and his or her nominated representative accordingly. Such a change of status does not preclude the person remaining as an independent patient, in appropriate circumstances.

(vii) Following discharge from Section 45, a readmission under Section 45 shall not take place for a period of 7 days from the date of discharge.. Any readmission within 7 days shall be considered as continuation of the admission and provisions of Section 46 shall apply.

Section 46:Admission and treatment of persons with mental illness, with high support needs, in a mental health facility, beyond 30 days (Supported Admission beyond 30 days)

i) Upon application by the nominated representative of a person with mental illness, the medical

officer in charge of a mental health facility shall continue admission of a person with mental illness in the facility under this section if :

a) The person is already admitted in a mental health facility under Section 45 and ;

b) Two psychiatrists have independently examined the person on the day of admission under this section or in the preceding 7 days and both conclude based on the examination and, if appropriate, on information provided by others that the person has a mental illness of a severity that the person :

(1) has consistently over time threatened or attempted to cause bodily harm to himself or herself; and/or

(2) has consistently over time behaved violently towards another person or has consistently over time caused another person to fear bodily harm from him or her; and/or

(3) has consistently over time shown a lack of competence to care for himself or herself to a degree that places the individual at risk of harm to himself or herself; and

c) both psychiatrists certify that admission to a mental health facility is the least restrictive care option possible in the circumstances and

d) the person continues to remain ineligible to receive care and treatment as a Independent Patient as the person is not competent to make decisions independently and needs very high support from their nominated representative, in making decisions.

(ii) All admissions or renewals under this section shall be informed by the mental health facility to the District Panel of the Mental Health Review Commission within 7 days of date of admission or renewal. Such admission or renewal shall be approved by the District Panel within a period of 21 days from the date it becomes effective. If the District Panel refuses to approve initial admission or renewal of admission, the person shall be discharged from the mental health facility.

While reviewing applications for renewals the District Panel shall critically examine the need for institutional care, in particular, why such care cannot be provided in less restrictive settings based in the community. The mere absence of community based services cannot by itself, provide sufficient justification for continued admission in the mental health facility. In all cases of application for renewal of admission under this section, the Mental Health Review Commission may demand that those in charge of treatment of the person with mental illness present a plan for community based treatment and the progress made, or is likely to be made, towards realizing this plan for community based treatment.

(iii) Admission of a person with mental illness to a mental health facility under this section will be limited to a period of 90 days. Further admission beyond this period, can be renewed for 90 days at each instance, upon application by the nominated representative of the person, to the medical officer in charge of the mental health facility and by following the procedure laid out in sub-section (i) and subsection

(ii) above. If the District Panel refuses to approve admission or renewal under this section as stated in sub-section (ii) above, or at the end of this period and no renewal has been made, or earlier if the person no longer meets the criteria for admission as stated in sub-section (i) above, the person shall cease to be kept admitted in the facility under this section.

(iv) Treatment shall only be provided taking into account any existing Advance Directive as per Section 5, if any or if the person, with the support of his nominated representative has given his informed consent to the treatment plan. The person may require a very high level of support from the nominated representative approaching 100 % support, where the nominated representative temporarily consents to treatment on behalf of the patient. In all instances where the level of support required is of a such a high degree that the nominated representative has to temporarily consent to treatment on behalf of the

person, the medical officer in charge of the facility should record this in the notes and this should

be reviewed every 15 days.

(v) A person admitted under this section, or his or her nominated representative on his or her behalf or a representative of a registered non-governmental organization with the consent of the person, may apply to the District Panel of the Mental Health Review Commission for review of the decision to

admit him or her in the mental health facility under sub-section (i) above and the decision of the District Panel shall be binding on all parties. All mental health facilities shall prominently display within the facility, the contact details including address and telephone numbers of the District Panel of the Mental Health Review Commission. The mental health facility shall provide the person with necessary forms to apply to the District Panel of the Mental Health Review Commission and also give free access to make telephone calls to the District Panel to apply for a review of the admission. In exceptional circumstances, the District Panel shall accept an application for review from a person admitted to a mental health facility, verbally over the telephone.

(vi) Notwithstanding anything contained in this Act, if the medical officer in charge of the facility becomes aware that the conditions in sub-section (i) are no longer met, the medical officer in charge shall terminate the admission under this section, and inform the person and his or her nominated representative accordingly. The person may continue to remain in the mental health facility as an Independent Patient, in appropriate circumstances.

Section 47 : Leave of Absence

(i) The medical officer in charge of a mental health facility may grant leave to any person admitted under Sections 43, 45 and 46 above, to be absent from the facility subject to such conditions (if any) and for a duration as the medical officer considers necessary. Such leave shall not extend beyond the period of the duration of admission permitted under Sections 43, 45 or 46. The medical officer shall secure the consent of the nominated representative before taking a decision granting leave.

(ii) The medical officer in charge may in writing terminate the leave of absence under this part, when appropriate to do so.

(iii) When an individual does not return to the facility following the expiry or termination of his or her leave of absence, the medical officer in charge will normally first contact the person on leave and his or her nominated representative. If the person with mental illness and his or her nominated representative feel that continued admission in the mental health facility is not necessary, they will convey this to the Medical Officer, who will formally discharge the person from the mental health facility after following all the procedures for discharge from the mental health facility.

(iv) However, if the medical officer in charge has grounds to believe that the person requires ongoing admission to a mental health facility and the nominated representative agrees with this assessment of the medical officer in charge and the person refuses to return to the hospital following expiry or termination of his or her leave of absence, the medical officer may ask the Police Officer in charge of the police station within the limits of whose station the mental health facility is located, to convey the person back to the mental health facility. A person not returned by the Police Officer within one month of expiry or termination of his or her leave of absence, may not be returned to the mental health facility under this section and will be considered as discharged from the facility. This does not preclude re-

admission otherwise, if the relevant substantive and procedural requirements are met.

Section 48: Absence without leave or discharge

(i) If a person admitted to mental health facility under Sections 43, 44 (iii), 45, 46 and 59 absents himself or herself without leave or without discharge from the mental health facility, he or she shall be taken into protection by any Police Officer at the request of the medical officer in charge of the facility and taken back to the mental health facility immediately.

(ii) Provided that in the case of a person with mental illness not admitted under Section 59, the

power to take in protection and take back to the mental health facility as aforesaid under this section shall not be exercisable after the expiry of a period of one month from the date of such absence from the mental health facility.

Section 49 :Transfer of persons with mental illness from one mental health facility to another mental health facility

(i) A person with mental illness admitted to a mental health facility under Sections 43, 45, 46 or 59 may, subject to any general or special order of the District Panel be removed from such mental health facility to another mental health facility within the State or with the consent of the Mental Health. Review Commission to any mental health facility in any other State. Provided that no person with mental illness admitted to a mental health facility under an order made in pursuance of an application made under the Act shall be so removed unless intimation and reasons for the transfer have been given to the person with mental illness and his or her nominated representative.

(ii) The State Government may make such general or special order as it thinks fit directing the removal of any prisoner with mental illness from the place where he or she is for the time being detained, to any mental health facility or other place of safe custody in the State or to any mental health facility or other place of safe custody in any other State with the consent of the Government of that other State.

Section 50: Emergency Treatment

(i) Notwithstanding anything contained in this Act, any medical treatment, including treatment for mental illness, may be provided by any registered medical practitioner to a person with mental illness either at a health facility or in the community, subject to the informed consent of the nominated representative, where the nominated representative is available, and where it is immediately necessary to prevent:

a) death or irreversible harm to the health of the person or;

b) the person inflicting serious harm to himself or herself or to others; or

c) the person causing serious damage to property belonging to himself or herself or to others

where such behaviour is believed to flow directly from the person's mental illness.

(ii) Nothing in this section shall be taken to permit medical treatment that is not directly related to the emergency identified in sub-section (i).

(iii) Nothing contained in this section shall permit the use of Electro-convulsive therapy as a form of treatment.

(iv) Nothing in this section shall be taken to permit treatment of more than 72 hours or till the person

has been assessed at a mental health facility, whichever is earlier, except in disasters or emergencies declared by the Government, the period of emergency treatment may be extended upto 7 days.

Section 51 : Prohibited treatments

Notwithstanding anything contained in this Act, the following treatments shall not be performed on any person with mental illness:

(i) Electro-convulsive therapy without the use of muscle relaxants and anesthesia

(ii) Electro-convulsive therapy for minors

(iii) Sterilization of men or women, when such sterilization is intended as a treatment for mental illness or

(iv) Persons with mental illness shall not be chained in any manner or form whatsoever.

Section 52: Restriction on Psychosurgery for Persons with Mental Illness

Notwithstanding anything contained in the Act, psychosurgery shall not be performed as a treatment for mental illness unless the following conditions are met :

(i) informed consent of the person on whom the surgery is being performed and ;

(ii) approval from the State Mental Health Authority to perform the surgery.

The State Mental Health Authority may, from time to time, make regulations for the purpose of carrying out the provisions of this section.

Section 53: Restraints and Seclusion

(i) Physical restraint or seclusion may only be be used when it is the only means available to prevent imminent and immediate harm to person concerned or to others.

(ii) Physical restraint or seclusion may only be used if it is authorized by the psychiatrist in charge of the person's treatment at the mental health facility.

(iii) Physical restraint or seclusion shall not be used longer than is absolutely necessary to prevent the immediate risk of significant harm.

(iv) The medical officer in charge of the mental health facility shall be responsible for ensuring that the method, nature of restraint or seclusion, justification for its imposition and the duration of the restraint or seclusion are immediately recorded in the person's medical notes.

(v) In no case will restraint or seclusion be used as a form of punishment, and under no circumstances shall lack of staff at the mental health facility be permitted as a reason for use of restraint or seclusion.

(vi) The nominated representative of the person with mental illness shall be informed about every instance of seclusion or restraint within a period of 24 hours.

(vii) A person who is placed under restraint or seclusion shall be kept under regular ongoing supervision of the medical personnel at the mental health facility.

(viii) All instances of restraint and seclusion at the mental health facility shall be included in a report to be sent to the District Panel on an monthly basis.

(ix) The District Panel may from time to time, make regulations for the purpose of carrying out the provisions of this section.

(x) The District Panel may order a mental health facility to desist from applying restraint and seclusion if the Panel is of the opinion that the mental health facility is persistently and willfully ignoring the provisions of this section.

Section 54: Discharge Planning

Whenever a person undergoing treatment for mental illness in a mental health facility is to be discharged into the community or to a different mental health facility or where a new psychiatrist is to

take responsibility of the person's care and treatment, the psychiatrist who has been responsible for the person's care and treatment shall consult with the person with mental illness, the nominated representative, the family member or care-giver with whom the person with mental illness will reside on discharge from the hospital, the psychiatrist expected to be responsible for the person's care and treatment in the future, and such other persons as may be appropriate, as to what treatment or services would be appropriate for the person. The psychiatrist responsible for the person's care shall in consultation with the above mentioned persons ensure that a plan is developed as to how these services shall be provided. Discharge planning applies to all discharges from mental health facilities. This section creates no right to impose treatment without consent.

Section 55: Research

(i) Free and informed consent shall be obtained by the professionals conducting the research, from all persons with mental illness for participation in all research especially that involving interviewing the person or psychological, physical, chemical or medicinal interventions.

(ii) In case of research involving any psychological, physical, chemical or medicinal interventions to be conducted on persons who are unable to give free and informed consent but do not resist participation in such research, permission to conduct such research must be obtained from concerned State Mental. Health Authority. The State Mental Health Authority may allow the research to proceed based on informed consent being obtained from the nominated representative of persons with mental illness, subject to the State Mental Health Authority having reviewed

the proposed research is satisfied that :

a) the research cannot reasonably be performed on persons who are capable of giving free and informed consent

b) the research is necessary to promote the health of the individual person and the population represented

c) the purpose of the research is to obtain knowledge relevant to the particular health needs of persons with mental illness

d) a full disclosure of the interests of persons and/or organizations conducting such research has been made and there is no conflict of interest involved

e) the proposed research follows all the national and international guidelines and regulations concerning the conduct of such research and in particular, ethical approval has been obtained from the institutional ethics committee where such research is to be conducted. This sub-section does not restrict research based study of the case notes of persons who are unable to give informed consent, so long as the anonymity of the persons is secured.

Chapter VIII : Responsibilities of Other Agencies

Section 56 : Duties of police officers in respect of persons with mental illness

(i) Every officer in charge of a police station :

(a) has a duty to take or cause to be taken into protection any person found wandering at large within the limits of his station whom he has reason to believe has mental illness and is incapable of taking care of himself or;

(b) has a duty to take or cause to be taken into protection any person within the limits of his station whom he has reason to believe to be a risk to himself or others by reason of mental illness.

(ii) A person taken into protection under sub-section (i) shall be informed of the grounds for taking him or her into such protection or if in the opinion of the officer taking the person into protection, the person has difficulty in understanding those grounds, his nominated representative, if any, is informed of such grounds.

(iii) Every person who is taken into protection by a police officer under this section shall be taken to the nearest public health facility within a period of 24 hours for assessment of the person's health care needs. Under no circumstances shall the person be detained in a police lock up or a prison facility. The medical officer in charge of the health facility shall be responsible for arranging the assessment of the person at the nearest mental health facility and the needs of the person with mental illness will be addressed as per other provisions of the Act as applicable in the particular circumstances. After assessment at the mental health facility if the person is found not to have a mental illness of a nature or degree requiring admission to the mental health facility, the medical officer in charge of the facility shall inform this to the Police Officer and the the Police Officer shall have a duty to convey the person to their residence or in case of homeless persons, to a government facility for homeless persons.

Section 57 : Order in case of person with mental illness who is ill treated or neglected

(i) Every officer in charge of a police station, who has reason to believe that any person within the limits of his station who has a mental illness and is ill-treated or neglected shall forthwith report the fact to the Magistrate within the local limits of whose jurisdiction the person with mental illness resides.

(ii) Any private person who has reason to believe that a person has mental illness and is ill-treated or neglected by any person having responsibility for care of this person, may report the fact to the Magistrate within the local limits of whose jurisdiction the person with mental illness resides.

(iii) If the Magistrate has reason to believe based on the report of a police officer or on the report or information given by any other person, or otherwise, that any person with mental illness within the local limits of his jurisdiction is ill-treated or neglected the Magistrate may cause the person

with mental illness to be produced before him and make an order under Section 58.

Section 58 : Conveying or admitting a person with mental illness to a mental health facility by a Magistrate

(i) When any person with mental illness appears or is brought before a Magistrate, the Magistrate may, order in writing :

(a) that the person is conveyed to a public mental health facility for assessment and treatment if necessary. At the mental health facility, the person will be dealt with as per other provisions of the Act as applicable in the particular circumstances or ;

(b) authorise the admission of the person with mental illness in a mental health facility for such period not exceeding ten days as the Magistrate may consider necessary for enabling any medical officer to carry out an assessment of the mental illness and to plan for necessary treatment, if any. On completion of the period of assessment, the person will be dealt with as per other provisions of the Act as applicable in the particular circumstances.

Section 59 : Prisoners with mental illness

(i) An order under Sec. 30 of the Prisoners Act, 1900 (3 of 1900) or under Sec. 144 of the Air Force. Act, 111950 (45 of 1950), or under Sec. 145 of the Army Act 1950 (46 of 1950), or under Sec. 143 or Sec. 144 of the Navy Act, 1957 (62 of 1957), or under Sec. 330 or Sec. 335 of the Code of Criminal Procedure 1973 (2 of 1974), directing the admission of a prisoner with mental illness into any mental health facility, shall be sufficient authority for the admission of such person in such facility to which such person may be lawfully transferred for detention therein.

(ii) The responsible medical officer of a prison or jail shall send quarterly reports to the District Panel certifying that there are no prisoners with mental illness in the prison or jail. The District Panel may visit the prison or jail if it wishes to do so. The District Panel also has the right to question the responsible medical officer as to why prisoners with mental illness if any, are in the prison or jail and not transferred for treatment to a mental health facility.

(iii) The medical officer in charge of a mental health facility wherein any person referred to in subsection

(i) is detained, shall once in every six months, make a special report regarding the mental and physical condition of such person to the authority under whose order such person is detained.

Section 60 : Question of Mental Illness in Judicial Process

(i) Notwithstanding anything contained in any other Act, proof of a person's current or past admission to a mental health facility or proof of a person's current or past treatment for mental illness shall not by itself be ground for granting divorce.

(ii) If during any judicial process before any competent court proof of mental illness is produced and is challenged by the other party, the court shall refer the same for further scrutiny to the District Panel of Mental Health Review Commission and the District Panel after examination of the person alleged to have a mental illness, either by itself or through a committee of experts, shall certify its opinion to the relevant court.

Chapter IX : Penalties and Miscellaneous provisions

Section 61: Penalties for establishing or maintaining a mental health facility in contravention of Chapter VI

(i) Whoever carries on a mental health facility without registration shall, on conviction, be punishable with imprisonment for a term which may extend to six months and/or for first offence, be punishable with a fine upto fifty thousand rupees, for second offence with fine which may extend to two lakh rupees and for subsequent offences with fine which may extend to five lakh rupees

(ii) Whoever knowingly serves in a mental health facility which is not duly registered under this Act, shall be punishable with a fine which may extend to twenty five thousand rupees.

(iii) Whoever fails to pay the fine, the Authority may prepare a certificate specifying the amount of fine due from such person or mental health facility and send it to the Collector of the District in which such person owns any property or resides or carries on his business or profession or where the mental health facility is located, and the said Collector on receipt of such certificate, shall proceed to recover from such persons or mental health facility the amount specified thereunder, as if it were an arrear of land revenue.

Section 62: General provision for punishment of offences

Any person who contravenes any of the provisions of this Act, or of any rule or regulation made thereunder shall be punishable with imprisonment for a term which may extend to six months, or with a fine which may extend to ten thousand rupees or both, for any subsequent offence punishable with imprisonment for a term upto two years or with fine minimum of fifty thousand which may extend to five lakh rupees.

Section 63 : Special relaxation in requirements for States of the North East Council

(i)The provisions of this section shall be applicable to the States belong to the North East Council as established under .....Act, taking into consideration travel and transportation difficulties in the States of the North East Council.

(ii) For the states included under sub-section (i) above, the following relaxations shall apply :

(a) Under Section 22 sub-section (iii), the President of the Commission may appoint a single Committee for all the states.

(b) Under Section 27 sub-section (ii) and sub-section (iii) where a period of 7 days is mentioned it shall be read as a period of 10 days and where a period of 21 days is mentioned it shall be read as a period of 30 days.

(c) Under Section 43 sub-section (vi) where a period of 72 hours is mentioned it shall be read as 120 hours and where a period of 7 days is mentioned it shall be read as 10 days.

(d) Under Section 44 sub-section (iii) where a period of 24 hours is mentioned it shall be read as 72 hours.

(e) Under Section 45 sub-section (iv) where a period of 3 days is mentioned it shall be read as 7 days and where a period of 7 days is mentioned it shall be read as 10 days.

(f) Under Section 46 sub-section (ii) where a period of 7 days is mentioned it shall be read as 10 days and where a period of 21 days is mentioned it shall be read as 30 days.

(g) Under Section 50 sub-section (iv) where a period of 72 hours is mentioned it shall be read as 120 hours

(iii) This section shall lapse at the end of 10 years from the date of the Act coming into force.

Section 64. Protection of action taken in good faith

(i) No suit, prosecution or other legal proceeding shall lie against any person for anything which is in good faith done or intended to be done in pursuance of this Act or any rules, regulations or orders made thereunder.

(ii) No suit or other legal proceeding shall lie against the Government for any damage caused or likely to be caused for anything which is in good faith done or intended to be done in pursuance of this Act or any rules, regulations or orders made thereunder.

Section 65. Effect of Act on other laws

The provisions of this Act shall have effect notwithstanding anything inconsistent therewith contained in any other law for the time being in force and to the extent of such inconsistency that other law shall be deemed to have no effect.

Section 66. Power to remove difficulty

If any difficulty arises in giving effect to the provisions of this Act in any State, the State Government may, by order, do anything not inconsistent with such provisions which appears to it to be necessary or expedient for the purpose of removing the difficulty.

Provided that no order shall be made under this section in relation to any State after the expiry of two years from the date on which this Act comes into force in that State.

Section 67. Repeal and Saving

(i)The Mental Health Act (1987) is hereby repealed.

(ii) Notwithstanding such repeal, anything done or any action taken under either of the said Acts shall, in so far as such thing or action is not inconsistent with the provisions of this Act, be deemed to have been done or taken under the corresponding provisions of this Act and shall continue in force until superseded by anything done or any action taken under this Act.