

A framework that emphasizes respect for persons requiring services would result in approaches that are interactive and not imposed (as is the case in most Western countries).

If the US-NIMH is concerned about the lives of people in LMI countries it should be in dialogue with representative stakeholders, and not impose solutions identified by non-representative experts.

We the undersigned are concerned activists and practitioners who come from different representative organizations like MFC, Anveshi and CAMH in India, and Survivor Research, ICPN, the UK.

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Psychiatric advance directives: cultural reflections

The article by Sarin et al (1) on the subject of psychiatric advance directives (PADs) raises new problems which are particularly challenging in the Indian context. The debate so far has focused on issues of competence, access, resources and legal dilemmas. What is missing is a discussion on the cultural aspects of mental healthcare for the Indian population.

Advanced directives are anchored in the bioethical principle of autonomy. The concept of autonomy as applied in western biomedicine implies self-determination and individual independence. This may not be the case in a different cultural context (2,3). Sarin et al have rightly pointed out, but not elaborated on, the role of family/key caregivers' preferences and views, and their impact on PADs and decision-making. This is also suggested in research findings on advanced directives in end-of-life care in cultures outside Europe and North America. Thus autonomy may imply "self-sovereignty" and "individual independence" in one culture, but "family-sovereignty" and "harmonious dependence" in another (3).

There is a more contentious issue related to the dominant form of mental healthcare legitimised by the state, in policy, programmes, and state-sponsored services. Research in mental

healthcare (4-9) has made evident the cultural construction of dominant biomedical paradigms of psychiatric care, and reveals the existence of other types of care that do not rely on biomedical treatment.

However, given the domination of biomedical treatment, requests for other types of care may be interpreted as non-viable. Under the circumstances the clinician may overrule PADs apparently in support of beneficence at the cost of autonomy.

In other words, legal instruments such as PADs may justify cultural bias and further marginalise those who seek mental healthcare outside mainstream medicine. As a result, they defeat the purpose of non discrimination and enhanced mutual acceptability of treatment decisions (1) for which PADs have been designed.

Sarin et al recommend research in PADs around feasibility, acceptability and effectiveness, in the Indian context. This can be advanced by culturally informed research. And, because personal integrity is threatened in severe mental disorders, primarily due to loss of insight, it is important to research these disorders and people's preferred methods for restoration, of integrity. This is because people's preferences relate to PADs in a definite manner.

The paper by Sarin et al is commendable, considering the variety of issues it brings to the fore that may add substantial value to the discourse on PADs. To be a fruitful legal mechanism, PADs should facilitate the aligning of culturally appropriate services with treatment needs.

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