Uttaranchal High Court

Dr. Vijay Verma vs Union Of India And Others on 1 June, 2018

IN THE HIGH COURT OF UTTARAKHAND AT NAINITAL

Writ Petition (PIL) No.17 of 2018

Dr. Vijay Verma .... Petitioner

Versus

Union of India & others ... Respondents

Mr. Ajay Veer Pundir, Advocate, for the petitioner.

Mr. Sanjay Bhatt, Advocate, for the respondent no.1.

Mrs. Prabha Naithani, Brief Holder, for the State of Uttarakhand.

Dated: June 01, 2018

Coram: Hon'ble Rajiv Sharma , J.

Hon'ble Sharad Kumar Sharma, J.

Per: Hon. Rajiv Sharma, J.

1) The present petition has raised a question of grave public importance. Petitioner has highlighted the plight of mentally disturbed ill children. These children, at times, do not even get proper food, care and medicines. These children are forced to live in miserable conditions. They are deprived of their fundamental and statutory rights. The government agencies have failed to protect these children. The mentally disturbed children, more particularly females, are sexually exploited. These children, due to their disability, are not in a position to complain about the torture or sexual offences committed against them. Petitioner has made representations before the respondent-State, vide Annexure No.2, for taking remedial measures to improve the conditions of children living with disability.

2) The State Government has not made any Policy to ameliorate the conditions of children suffering from mental illness. In view of this, this Court, by order dated 25.1.2018, issued the following directions to the respondents: -

> "It is directed that the respondents shall collect the complete data of the mentally retarded persons in the State of Uttarakhand and will also submit details as to how many mentally retarded persons are living their life on the streets. The respondents will also submit a report stating as to how many mentally retarded persons are getting treatment in the Mental Hospital, Selaqui, Vikasnagar and as to how many Doctors are present there. A report will also be submitted stating therein as to how many mentally retarded persons have been cured in the last two years and what action has been taken for their rehabilitation.

> It is further directed that the data will also be supplied regarding those mentally retarded persons, who are not getting treatment and have been kept by their family members in chains. A complete survey be done and after completion of the survey, the report be submitted positively within a period of six weeks.
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> It is further directed that in the meantime, those mentally retarded persons, who are found on the streets may immediately be sent to Medical Hospital for their treatment."

3) Though, initially, the present petition was filed for framing a Policy to register all mentally disturbed children and to take remedial measures, if deemed necessary, by legislation, however, the scope of the petition was enlarged as per order dated 25.1.2018, quoted hereinabove.

4) Thereafter, the counter affidavit was filed by the respondent no.5-Director General, Health. According to the averments contained in the reply, the State has established the District Early Intervention Centers (DEICs) at Almora, Roorkee, Haldwani and Dehradun with the aim and object to early detect and intervene so as to minimize the disabilities among growing children. The fully functional facilities like Special New Born Care Units (SNCUs) and New Born Stabilization Units (NBSUs) have already been established in the State which targets vulnerable newborns for continued special care at home and stabilization of sick new born so that the prevalence of mentally retarded children could be reduced. The State Mental Health Institute at Selaqui has also been set up to provide medication and to ensure the psychological well being of mentally retarded person including children.

5) The State Government has not framed any Policy to register all mentally disturbed children within six months from their birth, however, the respondent nos.3 and 5 are working to frame such a policy in the near future.

6) The District Early Intervention Centers are equipped with well qualified Teams consisting of Pediatrician, Medical Officer, Dentist, Physiotherapist, Psychologist, Counsellors, Managers, Technicians etc.

7) It is further averred that no mentally disturbed/ill person was ever chained or will be chained in future. The mental health department of Dr. Sushila Tiwari Govt. Hospital, Haldwani is also conducting diagnosis and treating the mentally retarded children on every Tuesday and Friday of the week.

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8)        It is further averred that it is the aim of the
respondents       to     provide       equal    opportunities       for
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development to all children during the period of their growth. The respondents have gathered the data regarding mentally retarded persons from almost all the districts of the State as per Annexure No.CA1.

9) On 15.2.2018, the Senior Psychiatrists have sent a communication to the Chief Medical

Superintendent, State Mental Health Institute, Selaqui, Dehradun, making a startling revelation that there is no Epidemiological Survey Data in the State on mental retardation and mental illness.

10) There is only one mental institute in Uttarakhand namely State Mental Health Insitute,

Selaqui (Dehradun) with total indoor capacity of 30 beds only. The State Mental Health Insitute, Selaqui has admitted 106 patients in 2016 and 96 patients in 2017. There is an urgent need to undertake Epidemiological Survey in the State to be conducted by a public health agency or an apex institute which has resources to conduct such survey in a systematic way.

11) The Parliament has enacted the Mental Healthcare Act, 2017 (hereinafter to be referred as 'the Act') to provide for mental healthcare and services for persons with mental illness and to protect, promote and fulfill the rights of such persons during delivery of mental healthcare and services and for matters connected therewith or incidental thereto.

12) Section 2(g) of the Act defines 'clinical psychologist'. Section 2(o) of the Act defines 'mental healthcare'. Section 2(s) of the Act defines 'mental illness'.

13) Section 3(1) provides that Mental illness shall be determined in accordance with such nationally or internationally accepted medical standards (including the latest edition of the International Classification of Disease of the World Health Organisation) as may be notified by the Central Government.

14) Section 3(2) provides that no person or authority shall classify a person as a person with mental illness, except for purposes directly relating to the treatment of the mental illness or in other matters as covered under this Act.

15) As per Section 5, every person, who is not a minor, shall have a right to make an advance directive in writing, specifying (a) the way the person wishes to be cared for and treated for a mental illness; (b) the way the person wishes not to be cared for and treated for a mental illness; (c) the individual or individuals, in order of precedence, he wants to appoint as his nominated representative as provided under section 14.

16) Every person, under Section 18, has a right to access mental healthcare and treatment from mental health services run or funded by the appropriate Government. The right to access mental healthcare and treatment shall mean mental health services at affordable cost, of good quality, available in sufficient quantity, accessible geographically, without any discrimination as per Section 18(2).

17) Every person with mental illness has a right to live in, be part of and not to be segregated from society u/s 19.

18) As per Section 20, every person with mental illness has a right to live with dignity and protection from cruel, inhuman and degrading treatment.

19) Section 29 enjoins on Government to plan, design and implement programmes for the promotion of mental health and prevention of mental illness in the country.

20) It is the duty of the appropriate government as per Section 30 to create awareness about mental health and illness and reducing stigma associated with mental illness.

21) The government is required to take measures as regard to human resource development and training u/s 31 of the Act.

22) Section 45 provides that the State Government, shall, within a period of nine months from the date on which this Act receives the assent of the President, by notification, establish, for the purposes of this Act, an Authority to be known as the State Mental Health Authority. The composition of State Authority is provided u/s 46 of the Act. The functions of the State Authority are enumerated u/s 55.

23) Section 65 provides that no person or Organisation shall establish or run a mental health establishment unless it has been registered with the Authority under the provisions of this Act.

24) Section 73 provides that the State Authority shall, by notification, constitute Boards to be called the Mental Health Review Boards for the purposes of the Act.

The functions to be discharged by the Board are provided u/s 82.

25) The procedure for admission, treatment and discharge has been provided under Chapter XII of the Act. A minor can be admitted to Mental Health Establishment as per the procedure prescribed under Section 87.

26) Section 95 provides that the treatments like electro-convulsive therapy without the use of muscle relaxants and anaesthesia cannot be undertaken.

27) As per Section 97, a person with mental illness cannot be subjected to seclusion or solitary confinement.

28) Section 100 empowers the police officers in respect of persons with mental illness. It is the duty of every medical officer of a prison to send a quarterly report to the concerned Board certifying therein that there are no prisoners with mental illness in the prison or jail.

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29)          Section 121 empowers the State Government
to frame the Rules.

30)          Section 123 empowers the State Authority to
make regulations.
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31) There are 236 mentally disabled persons in

Almora, 38 in Bageshwar, 187 in Champawat, 270 in Dehradun, 320 in Nainital, 106 in Pauri Garhwal, 313 in Tehri Garhwal, 1421 in Udham Singh Nagar and 164 persons in Uttarkashi. Out of them, 44 persons were found roaming in the streets of Champawat and 04 persons in the streets of District Nainital.

32) There are 06 institutions registered in District Dehradun, 03 institutions in District Haridwar and 03 institutions in District Nainital for care and protection of mentally ill persons.

33) The State Government is also paying the pension of Rs.1,000/- per month to the mentally ill persons above 18 years and Rs.700/- per month to the mentally ill persons below 18 years.

34) The District Early Intervention Centers are set up only in Almora, Roorkee, Haldwani and Dehradun. These are required to be set up in ever district headquarters.

35) Every person with mental illness is entitled to clean, safe and hygienic environment, adequate sanitary conditions, reasonable facilities for leisure, recreation, education and religious practices, food, proper clothing to protect such person from exposure of his body to maintain his dignity, and not be subjected to compulsory tonsuring (shaving of head hair), to be protected from all forms of physical, verbal, emotional and sexual abuse in any mental health establishments run by the State and granted permission by any private institution provided approval by it.

36) The Division of Mental Health & Prevention of Substance Abuse, World Health Organization, Geneva 1996 has described Ten Basic Principles of Mental Health Care Law as under: -

"1. Promotion of Mental Health and Prevention of Mental Disorders Description Everyone should benefit from the best possible measures to promote their mental well-being and to prevent mental disorders.

Components This principle includes the following components:

1. Mental health promotion efforts;

2. Mental disorders prevention efforts.

Implementation Selected actions suggested to promote this principle include:

1. Promoting behaviours which contribute to enhancing and maintaining mental well-being.

2. Identifying and taking appropriate actions to eliminate the causes of mental disorders.

2. Access to Basic Mental Health Care Description Everyone in need should have access to basic mental health care. Components This principle includes the following components:

1. Mental health care should be of adequate quality, i.e.: a. preserve the dignity of the patient;

b. take into consideration and allow for techniques which help patients to cope by themselves with their mental health impairments, disabilities and handicaps;

c. provide accepted and relevant clinical and nonclinical care aimed at reducing the impact of the disorder and improving the quality of life of the patient;

d. maintain a mental health care system of adequate quality (including primary health care, outpatient, inpatient and residential facilities);

2. Access to mental health care should be affordable and equitable;

3. Mental health care should be geographically accessible;

4. Mental health care should be available on a voluntary basis, as health care in general;

5. Access to health care, including mental health care, is contingent upon the available human and logistical resources.

Implementation Selected actions suggested to promote this principle are:

1. Having a specific provision in the law which guarantees quality health care, preferably a general provision on health care applying to mental health by extension;

2. Having medical practices in keeping with quality assurance guidelines such as those developed by WHO;

3. Having developed and/or adapted at national level quality assurance guidelines and instruments by and for all qualified professionals or governmental bodies;

4. Offering mental health care which is culturally appropriate;

5. Calling for and taking into consideration the patient's assessment of the quality of care;

6. Having treatments, decisions and measures regarding a person to whom mental health care is provided, documented in the person's medical record;

7. Introducing a mental health component into Primary Health Care;

8. Promoting health insurance programs (public or private) offering coverage to the widest possible number of individuals and which do not exclude but specifically include mental health care;

9. Having a voluntary admission procedure incorporated into the mental health law scheme which is abided by in practice;

10. Having mental health care geographically "accessible" according to WHO's indications, i.e.: a. by making basic mental health care available within one hour walking or travelling distance; and b. by making available the essential drugs identified by WHO (or drugs of the same family with similar properties: amitriptyline, biperiden, carbamazepine, chlorpromazine, clomipramine, diazepam, fenobarbitone, fluphenazine decanoate, haloperidol, imipramine, lithium carbonate and temazepam).

3. Mental Health Assessments in Accordance with Internationally Accepted Principles Description Mental health assessments should be made in accordance with internationally accepted medical principles and instruments (e.g: WHO's ICD-10 Classification of Mental and Behavioural Disorders - Clinical Descriptions and Diagnostic Guidelines, Tenth Revision, 1992).

Components This principle includes the following components:

1. Mental health assessments include:

a. diagnosis;

b. choice of a treatment;

c. determination of competence;

d. determination that someone may cause harm to self or others due to a mental disorder;

2. Mental health assessments should only be conducted for purposes directly relating to mental illness or the consequences of mental illness.

Implementation Selected actions suggested to promote this principle are:

1. Promoting clinical training in the use of internationally accepted principles;

2. Refraining from referring to nonclinical criteria, such as political, economic, social, racial and religious grounds when assessing potential to cause harm to self or others;

3. Performing complete reassessments each time a new assessment is conducted;

4. Refraining from basing an assessment only on past medical history of mental disorder.

4. Provision of the Least Restrictive Type of Mental Health Care Description Persons with mental health disorders should be provided with health care which is the least restrictive. Components This principle includes the following components:

1. Items to be considered in the selection of least restrictive alternatives include:

a. the disorder involved;

b. the available treatments;

c. the person's level of autonomy;

d. the person's acceptance and cooperation; and e. the potential that harm be caused to self or others;

2. Community-based treatment should be made available to qualifying patients;

3. Institution-based treatments should be provided in the least restrictive environment and treatments involving the use of physical (e.g. isolation rooms, camisoles) and chemical restraints, if at all necessary, should be contingent upon:

a. sustained attempts to discuss alternatives with the patient; b. examination and prescription by an approved health care provider; c. the necessity to avoid immediate harm to self or others; d. regular observation;

e. periodical reassessments of the need for restraint (e.g. every half hour for physical restraint);

f. a strictly limited duration (e.g. 4 hours for physical restraint); g. documentation in patient's medical file.

Implementation Selected actions suggested to promote this principle are:

1. Maintaining legal instruments and infrastructures (human resources, sites, etc.) to support community-based mental health care involving settings for patients with various degrees of autonomy;

2. Taking steps to eliminate isolation rooms and prohibit the creation of new ones;

3. Amending relevant legal instruments to remove provisions incompatible with community-based mental health care;

4. Training mental health care providers in the use of alternatives to the traditional restraints to deal with crisis situations.

5. Self-Determination Description Consent is required before any type of interference with a person can occur.

Components This principle includes the following components:

1. Interference includes: a. bodily and mental integrity (e.g. diagnostic procedures, medical treatment, such as use of drugs, electroconvulsive therapy and irreversible surgery); b. liberty (e.g. mandatory commitment to hospital).

2. Consent must be:

a. given by the person involved, as may apply in keeping with cultures, after having obtained advice from any traditional decision-making unit (e.g. family, relative, work unit);

b. free (of undue influence);

c. informed (information to be accurate, understandable, sufficient for one to decide e.g. advantages, disadvantages, risks, alternatives, expected results, side-effects);

d. documented in the patient's medical file, except for minor interferences.

3. In case a person with a mental disorder is found to be unable to consent, which will typically be the case occasionally but not systematically, there should be a surrogate decision-maker (relative, friend or authority) authorized to decide on the patient's behalf and in the patient's best interest. Parents or guardians, if any, are to give consent for minors.

Implementation Selected actions suggested to promote this principle are:

1. Presuming that patients are capable of making their own decision unless proven otherwise;

2. Making sure that mental health care providers do not systematically consider that patients with a mental disorder are unable to make their own decisions;

3. Not systematically considering a patient to be unable to exercise self-determination with regard to all components (e.g. integrity, liberty) because the patient was found to be unable with regard to one (e.g. authority for involuntary hospitalization does not automatically include authority for involuntary treatment, especially if the treatment is invasive);

4. Giving verbal and written information (in an accessible language) to patients about the treatment; detailed verbal explanations should be provided to patients unable to read;

5. Calling for the patient's opinion regardless of his or her ability to consent and giving it careful consideration prior to carrying out actions affecting his/her integrity or liberty; asking someone deemed unable to decide about his/her own good to explain the motives behind a given opinion may unveil legitimate concerns for consideration and, as such, promotes the exercise of self-determination;

6. Abiding by any wishes expressed by a patient prior to becoming unable to consent.

6. Right to be Assisted in the Exercise of Self-Determination Description In case a patient merely experiences difficulties in appreciating the implications of a decision, although not unable to decide, he/she shall benefit from the assistance of a knowledgeable third party of his or her choice.

Components Difficulties may be due to various causes, including the following:

1. General knowledge;

2. Linguistic abilities;

3. Disability resulting from a health disorder.

Implementation Selected actions suggested to further respect of this principle include:

1. Informing the patient about this right at the moment he/she is faced with the need for assistance;

2. Suggesting potential assistants (e.g. a lawyer, a social worker);

3. Facilitating the involvement of the assistant, including offering assistance free of charge if possible;

4. Promoting the establishment of a structure offering assistance to mental patients (e.g. ombudsman, patients' (users') committee).

7. Availability of Review Procedure Description There should be a review procedure available for any decision made by official (judge) or surrogate (representative, e.g. guardian) decision- makers and by health care providers.

Components This principle includes the following components:

1. The procedure should be available at the request of interested parties, including the person involved;

2. The procedure should be available in a timely fashion (e.g. within 3 days of the decision);

3. The patient should not be prevented to access review on the basis of his/her health status;

4. The patient should be given an opportunity to be heard in person.

Implementation Selected actions suggested to promote this principle are: 1. Having a review procedure and/or a permanent Review Board created by legislation and which is operational; 2. Establishing a state-managed office of representatives for mental patients with legal and ombudsman-like services.

8. Automatic Periodical Review Mechanism Description In the case of a decision affecting integrity (treatment) and/or liberty (hospitalization) with a long-lasting impact, there should be an automatic periodical review mechanism. Components This principle includes the following components:

1. Reviews should take place automatically;

2. Reviews should take place at reasonable intervals (e.g. each time a six-month period has elapsed);

3. Reviews should be conducted by a qualified decision-maker acting in official capacity. Implementation Selected actions suggested to promote this principle are:

1. Appointing a review body to conduct this review;

2. Requiring members of the review body to meet patients and review cases at a set interval;

3. Entitling patients to meet the review body (this should be facilitated by the health authorities);

4. Requiring the review procedure to take place in full upon each occasion (the review body should ideally not be composed of the same person(s) if more than one automatic review occurs in a given case and it should not be unduly influenced by its previous decisions);

5. Sanctioning defaulting body members (e.g. those failing to carry out the tasks for which they are appointed).

9. Qualified Decision-Maker Description Decision-makers acting in official capacity (e.g. judge) or surrogate (consent-giving) capacity (e.g. relative, friend, guardian) shall be qualified to do so.

Components To be qualified, decision-makers should be:

1. Competent;

2. Knowledgeable;

3. Independent (if acting in official capacity);

4. Impartial (if acting in official capacity). Ideally, a decision-making body acting in an official capacity should be composed of more than one person (e.g. three) drawn from different relevant disciplines.

Implementation Selected actions suggested to promote this principle are:

1. Providing initial and continuing training to decision-makers acting in official capacity and/or their assistants in relevant disciplines, including, as needed, psychiatry, psychology, law, social services and other disciplines;

2. Disqualifying decision-makers with a direct personal interest in the determination at stake;

3. Providing sufficient remuneration to decision-makers acting in official capacity to guarantee independence in carrying out their duty.

10. Respect of the Rule of Law Description Decisions should be made in keeping with the body of law in force in the jurisdiction involved and not on another basis nor on an arbitrary basis Components This principle includes the following components:

1. Depending on the legal system of the country, the body of law may be found in different types of legal instruments (e.g. constitutions, international agreements, laws, decrees, regulations, orders) and/or in past court rulings (precedents);

2. The law applicable is the law in force at the time in question, as opposed to retroactive or draft legal instruments;

3. Laws should be public, accessible and made understandable. Implementation Selected actions suggested to promote this principle are: 1. Informing patients about their rights; 2. Making sure that relevant legal instruments are disseminated (e.g. published, explained in accessible language in guides, if necessary) to interested members of the public in general and to decision-makers in particular; 3. Providing training to decision-makers on the meaning and implications of the Rule of Law;

4. Drawing from relevant internationally accepted human rights' documents, (e.g. UN Principles, current Ten Basic Principles) to interpret the body of law in force in the jurisdiction involved;

5. Having the actual application of the mental health law scheme monitored by a control body independent from the health authorities and from the health care providers."

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37)         The      Department          of    Mental      Health      and
Substance      Dependence,       Non-communicable           Diseases
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and Mental health, World Health Organization, Geneva 2003 under the caption 'Investing in Mental Health' has highlighted the issues on Mental Illness; its prevention and cure. The 'mental health' has been described as under: -

"Mental health is more than the mere lack of mental disorders. The positive dimension of mental health is stressed in WHO's definition of health as contained in its constitution: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Concepts of mental health include subjective well-being, perceived self-efficacy, autonomy, competence, intergenerational dependence and recognition of the ability to realize one's intellectual and emotional potential. It has also been defined as a state of well-being whereby individuals recognize their abilities, are able to cope with the normal stresses of life, work productively and fruitfully, and make a contribution to their communities. Mental health is about enhancing competencies of individuals and communities and enabling them to achieve their self-determined

goals. Mental health should be a concern for all of us, rather than only for those who suffer from a mental disorder. Mental health problems affect society as a whole, and not just a small, isolated segment. They are therefore a major challenge to global development. No group is immune to mental disorders, but the risk is higher among the poor, homeless, the unemployed, persons with low education, victims of violence, migrants and refugees, indigenous populations, children and adolescents, abused women and the neglected elderly. For all individuals, mental, physical and social health are closely interwoven, vital strands of life. As our understanding of this interdependent relationship grows, it becomes ever more apparent that mental health is crucial to the overall well-being of individuals, societies and countries. Unfortunately, in most parts of the world, mental health and mental disorders are not accorded anywhere the same importance as physical health. Rather, they have been largely ignored or neglected."

38) According to the guidelines, as many as 450 million people suffer from a mental or behavioural disorder. According to WHO's Global Burden of Disease 2001, 33% of the years lived with disability (YLD) are due to neuropsychiatric disorders and a further 2.1% due to intentional injuries. It is also stated that mental disorders and medical illness are interrelated. Many psychiatric institutions have inadequate, degrading and even harmful care and treatment practices, as well as unhygienic and inhuman living conditions. The role of the family has been highlighted as under: -

"Family members are often the primary caregivers of people with mental disorders. They provide emotional and physical support, and often have to bear the financial expenses associated with mental health treatment and care. It is estimated that one in four families has at least one member currently suffering from a mental or behavioural disorder. In addition to the obvious distress of seeing a lovedone disabled by the consequences of a mental disorder, family members are also exposed to the stigma and discrimination associated with mental ill health. Rejection by friends, relatives, neighbours and the community as a whole can increase the family's sense of isolation, resulting in restricted social activities, and the denial of equal participation in normal social networks. Informal caregivers need more support. The failure of society to acknowledge the burden of mental disorders on affected families means that very little support is available to them. Expenses for the treatment of mental illness are often borne by the family because they are generally not covered by the State or by insurance. Family members may need to set aside a significant amount of their time to care for a person with a mental disorder. Unfortunately, the lack of understanding on the part of most employers, and the lack of special employment schemes to address this issue, sometimes render it difficult for family members to gain employment or to hold on to an existing job, or they may suffer a loss of earnings due to days taken off from work. This compounds the financial costs associated with treating and caring for someone with a mental disorder."

39) Mental illness affects access to the job market and job retention. In many developed countries, 35% to 45% of absenteeism from work is due to mental health problems. The mental disorder and poverty are also interrelated. The W.H.O. has declared the Year 2001 as the year of 'Mental Health'. The four core strategies of the Mental Health Global Action Programme read as under: -

"Strategy 1 Increasing and improving information for decision-making and technology transfer to increase country capacity.

WHO is collecting information about the magnitude and the burden of mental disorders around the world, and about the resources (human, financial, sociocultural) that are available in countries to respond to the burden generated by mental disorders. WHO is disseminating mental health-related technologies and knowledge to empower countries in developing preventive measures and promoting appropriate treatment for mental, neurological and substanceabuse disorders.

Strategy 2 Raising awareness about mental disorders through education and advocacy for more respect of human rights and less stigma.

The World Health Organization is establishing the first all- inclusive global partnership of mental health-related constituencies: the Global Council for Mental Health. It will act as a forum for mental health, stimulating and lending support to activities aimed at promoting implementation of the 10 recommendations of the World Health Report 2001 in all regions. Professional NGOs, family members and consumer groups, leaders of religious groups, parliamentarians, labour and business organizations are all enthusiastic about pursuing activities for the improvement of mental health through this common platform led by WHO.

Strategy 3 Assisting countries in designing policies and developing comprehensive and effective mental health services. The scarcity of resource forces their rational use.

The World Health Report 2001 and the Atlas: Mental Health Resources in the World, have revealed an unsatisfactory situation with regard to mental health care in many countries, particularly in developing countries. WHO is engaged in providing technical assistance to Ministries of Health in developing mental health policy and services. Building national capacity is a priority to enhance the mental health of populations. WHO has designed a mental health policy and service guidelines to address the wide variety of needs and priorities in policy development and service planning, and a manual on how to reform and implement mental health law. To put plans into action, WHO is adapting the level and types of implementation to the general level of resources of individual countries. In the particular case of developing countries, where the gap between mental health needs and the resources to meet them is greater, WHO will offer differentiated packages of "achievable targets" for implementation (Gap Reduction Achievable National Targets/GRANTs) to countries grouped by at least three levels of resources (low, middle and relatively higher). These packages provide the minimum required set of feasible actions to be undertaken to comply with the 10 recommendations spelt out in the World Health Report 2001. Achievement of the identified targets will influence both health and social outcomes, namely mortality due to suicide or to alcohol/illicit drugs, morbidity and disability due to the key mental disorders, quality of life, and, finally, human rights.

Strategy 4 Building local capacity for public mental health research in poor countries Besides advocacy, policy assistance and knowledge transfer, mhGAP formulates in some detail the active role that information and research ought to play in the multidimensional efforts required to change the current mental health gap at country level.

WHO is developing several projects and activities to promote this strategy at country level, including a research fellowship programme targeting developing countries. A project on the cost-effectiveness of mental health strategies is being implemented in selected countries to generate real estimates on the costs and benefits of mental health interventions. These estimates will then be used to enhance mental health services at country level.

40) In a well-researched Article 'Mental Health and the law' authored by Pratima Murty, B.C. Malathesh, C. Naveen Kumar and Suresh Bada Math reported in 2016 Dec; 58 (Suppl 2) in Indian Journal of Psychiatry has conceptualized the "Centre for Human Rights, Ethics, Law and Mental Health" with following objectives: -

"(a) enhancing trained human resources in the areas of forensic psychiatry, law and human rights of persons with mental illness,

(b) establishing and providing the highest standards in diagnostic and investigative approaches in forensic psychiatry,

(c) developing a state of art clinical and resource facility in forensic psychiatry,

(d) facilitating the development of quality forensic services in different parts of the country,

(e) contributing to capacity building by providing training in forensic psychiatry for mental health, medical, police personnel, human rights activists and law professionals,

(f) developing and strengthening inter-disciplinary, inter-institutional and international collaboration to foster research in forensic psychiatry,

(g) developing guidelines, standard operating procedures, providing expert opinion in the area of forensic psychiatry,

(h) conducting research with regard to mental health laws, medico- legal psychiatry, forensic psychiatry and child forensic psychiatry, and to

(i) guiding national policy and develop national guidelines for developing quality forensic psychiatric services in India."

41) The article captioned 'Lifestyle and Mental Health', Roger Walsh, University of California, Irvine College of Medicine, has highlighted the advantages of therapeutic lifestyle changes as under: -

"Exercise Exercise offers physical benefits that extend over multiple body systems. It reduces the risk of multiple disorders, including cancer, and is therapeutic for physical disorders ranging from cardiovascular diseases to diabetes to prostate cancer. Exercise is also, as the Harvard Mental Health Letter ("Therapeutic Effects," 2000, p. 5) concluded, "a healthful, inexpensive, and insufficiently used treatment for a variety of psychiatric disorders."

As with physical effects, exercise offers both preventive and therapeutic psychological benefits. In terms of prevention, both cross- sectional and prospective studies show that exercise can reduce the risk of depression as well as neurodegenerative disorders such as age-related cognitive decline, Alzheimer's disease, and Parkinson's disease. In terms of therapeutic benefits, responsive disorders include depression, anxiety, eating, addictive, and body dysmorphic disorders. Exercise also reduces chronic pain, age-related cognitive decline, the severity of Alzheimer's disease, and some symptoms of schizophrenia.

The most studied disorder in relation to exercise to date is mild to moderate depression. Cross-sectional, prospective, and meta-analytic studies suggest that exercise is both preventive and therapeutic, and in terms of therapeutic benefits it compares favorably with pharmacotherapy and psychotherapy. Both aerobic exercise and nonaerobic weight training are effective for both short-term interventions and long-term maintenance, and there appears to be a dose-response relationship, with higher intensity workouts being more effective. Exercise is a valuable adjunct to pharmacotherapy, and special populations such as postpartum mothers, the elderly, and perhaps children appear to benefit.

Possible mediating factors that contribute to these antidepressant effects span physiological, psychological, and neural domains. Proposed physiological mediators include changes in serotonin metabolism, improved sleep, as well as endorphin release and consequent "runner's high". Psychological factors include enhanced self-efficacy and self-esteem, interruption of negative thoughts and rumination, and perhaps the breakdown of muscular armor, the chronic psychosomatic muscle tension patterns that express emotional conflicts and are a focus of somatic therapies.

Neural factors are especially intriguing. Exercise increases brain volume (both gray and white matter), vascularization, blood flow, and functional measures;. Animal studies suggest that exercise-induced changes in the hippocampus include increased neuronogenesis, synaptogenesis, neuronal preservation, interneuronal connections, and BDNF (brain-derived neurotrophic factor, the same neurotrophic factor that antidepressants up-regulate.

Given these neural effects, it is not surprising that exercise can also confer significant cognitive benefits. These range from enhancing academic performance in youth, to aiding stroke recovery, to reducing age-related memory loss and the risk of both Alzheimer's and non- Alzheimer's dementia in the elderly. Multiple studies show that exercise is a valuable therapy for Alzheimer's patients that can improve intellectual capacities, social functions, emotional states, and caregiver distress.

Meta-analytic studies provide more fine-grained details about the cognitive benefits of exercise for the elderly and offer four kinds of good news. First, the effects can be large, reducing the risk of Alzheimer's disease by 45% and increasing cognitive performance by 0.5 SD. Second, though women may gain more than men, everyone seems to benefit, including both clinical and nonclinical populations. Third, improvements extend over several kinds of psychological functions, ranging from processing speed to executive functions. Fourth, executive functions, such as coordination and planning, appear to benefit most, a welcome finding given that executive functions are so important,

and that both they and the brain areas that underlie them are particularly age sensitive.

Finally, meta-analyses reveal the specific elements of exercise that benefit cognition. Relatively short programs of one to three months in length offer significant benefits, though programs of six months or longer are more beneficial. There seems to be a threshold effect for session duration, because sessions shorter than 30 minutes--while valuable for physical health--yield minimal cognitive gains. Cognitive benefits are enhanced by more strenuous activity and by combining strength training with aerobics. In short, research validates the words of the second U.S. president, John Adams, who wrote, "Old minds are like old horses; you must exercise them if you wish to keep them in working order".

Fortunately, even brief counseling can motivate many patients to exercise (Long et al., 1996), and the risks are minimal, although an initial medical exam may be warranted. Yet despite the many mental and medical benefits of exercise, only some 10% of mental health professionals recommend it. And who are these 10%? Not surprisingly, they are likely to exercise themselves.

Nutrition and Diet There is now considerable evidence of the importance of nutrition for mental health, and an extensive review of over 160 studies suggests that dietary factors are so important that the mental health of nations may be linked to them. Given the enormous literature on this topic, it is easy to feel overwhelmed. Therefore, the following sections review this complex literature but also distill easily communicable principles, because such ease of communication strongly influences whether therapists recommend and patients adopt such treatments. Two major dietary components must be considered: food selection and supplements.

Food Selection For food selection, the key principles for TLCs are to emphasize a diet that

1. Consists predominantly of multicolored fruits and vegetables (a "rainbow diet").

2. Contains some fish (a "pescovegetarian diet"): Preference should be given to cold deep-seawater fish (e.g., salmon), which are high in beneficial omega-3 fish oils, while avoiding the four species with high mercury levels (shark, swordfish, king mackerel, and tilefish).

3. Reduces excessive calories: For societies confronting the "globesity" epidemic, reducing excess calories offers both economic and public health benefits). For individuals, reducing excess calories offers medical and neuroprotective benefits. This neuroprotection is especially important in light of recent findings suggesting that adult obesity may be associated with reduced cognitive function, as well as reduced whiteand gray-matter brain volume. Fortunately, pescovegetarian diets are low in calories.

Multiple human and animal studies suggest that pescovegetarian diets may prevent or ameliorate psychopathologies across the life span. Such diets may enhance cognitive and academic performance in children as well as ameliorate affective and schizophrenic disorders in adults. They also offer neuroprotective benefits, as demonstrated by reductions in the incidence of age-related cognitive decline, Alzheimer's disease, and Parkinson's disease. Several studies of the Mediterranean

diet--including a meta-analysis of 12 prospective studies with over 1.5 million subjects--found reductions in the incidence of both Alzheimer's and Parkinson's diseases. Dietary elements that appear to be particularly neuroprotective include fish, vegetables, and perhaps fruit, as well as lower intake of animal fats. Of enormous public health importance are recent findings suggesting that, owing to epigenetic factors, "the effects of diet on mental health can be transmitted across generations".

Supplements Growing evidence suggests that food supplements offer valuable prophylactic and therapeutic benefits for mental health. Research is particularly being directed to Vitamin D, folic acid, SAME (S- adenosyl-methionine), and--most of all--fish oil.

Fish and fish oil are especially important for mental health. They supply essential omega-3 fatty acids, especially EPA (eicosapentaenoic acid) and DHA (docosahexaenoic acid), which are essential to neural function. Systemically, omega-3s are anti- inflammatory, counteract the pro-inflamatory effects of omega-6 fatty acids, and are protective of multiple body systems. Unfortunately, modern diets are often high in omega-6s and deficient in omega-3s.

Is this dietary deficiency associated with psychopalogy? Both epidemiological and clinical evidence suggest that it is. Affective disorders have been the ones most closely studied, and epidemiological studies, both within and between countries, suggest that lower fish consumption is associated with significantly, sometimes dramatically, higher prevalence rates of these disorders. Likewise, lower omega-3 levels in tissue are correlated with greater symptom severity in both affective and schizophrenic disorders, a finding consistent with emerging evidence that inflammation may play a role in these disorders. However, epidemiological studies of dementia and omega-3 fatty acid intake are as yet inconclusive.

Epidemiological, cross-sectional, and clinical studies suggest that omega-3 fatty acid supplementation may be therapeutic for several disorders. Again, depression has been the disorder most closely studied. Several meta-analyses suggest that supplementation may be effective for unipolar, bipolar, and perinatal depressive disorders as an adjunctive, and perhaps even as a stand-alone, treatment, although at this stage, supplementation is probably best used adjunctively. Questions remain about optimal DHA and EPA doses and ratios, although one meta-analysis found a significant correlation between dose and treatment effect, and a dose of 1,000 mg of EPA daily is often mentioned, which requires several fish oil capsules.

There are also cognitive benefits of supplementation. In infants, both maternal intake and feeding formula supplementation enhance children's subsequent cognitive performance. In older adults, fish and fish oil supplements appear to reduce cognitive decline but do not seem effective in treating Alzheimer's disease.

The evidence on omega-3s for the treatment of other disorders is promising but less conclusive. Supplementation may benefit those with schizophrenia and Huntington's disease as well as those exhibiting aggression in both normal and prison populations. In children, omega-3s may reduce aggression and symptoms of attention-deficit/hyperactivity disorder.

A particularly important finding is that fish oils may prevent progression to first episode psychosis in high-risk youth. A randomized, double-blind, placebo-controlled study was conducted of 81 youths between 13 and 25 years of age who had subthreshold psychosis. Administering fish oil with 1.2 g of omega-3s once per day for 12 weeks reduced both positive and negative symptoms as well as the risk of progression to full psychosis. This risk was 27.5% in controls but fell to only 4.9% in treated subjects. Particularly important was the finding that benefits persisted during the nine months of follow-up after treatment cessation. Such persistence has not occurred with antipsychotic medications, which also have significantly more side effects. Although coming from only a single study, these findings suggest another important prophylactic benefit of fish oils.

With one exception, risks of fish oil supplementation at recommended doses are minimal and usually limited to mild gastrointestinal symptoms. The exception occurs in patients on anticoagulants or with bleeding disorders, because fish oils can slow blood clotting. Such patients should therefore be monitored by a physician.

Omega-3s modify genetic expression and as such are early exemplars of a possible new field of "psychonutrigenomics." Nutrigenomics is an emerging discipline that uses nutrients to modify genetic expression. Because genetic expression is proving more modifiable, and nutrients more psychologically important than previously thought, psychonutrigenomics could become an important field.

Space limitations allow only brief mention of another significant supplement, Vitamin D. Vitamin D is a multipurpose hormone with multiple neural functions, including neurotrophic, antioxidant, and anti-inflammatory effects. Vitamin D deficiency is widespread throughout the population, especially in the elderly, and exacts a significant medical toll; several studies suggest associations with cognitive impairment, depression, bipolar disorder, and schizophrenia. Mental health professionals are therefore beginning to join physicians in recommending routine supplementation (usually 600 units per day) and, where indicated, testing patients' Vitamin D blood levels and modifying supplement levels accordingly.

There are further benefits to supplementation and pescovegetarian diets. First, they have multiple general health benefits and low side effects. Second, they may ameliorate certain comorbid disorders-- such as obesity, diabetes, and cardiovascular complications--that can accompany some mental illnesses and medications. A diet that is good for the brain is good for the body. As such, dietary assessment and recommendations are appropriate and important elements of mental health care.

Nature Imagine a therapy that had no known side effects, was readily available, and could improve your cognitive functioning at zero cost. Such a therapy has been known to philosophers, writers, and laypeople alike: interacting with nature. Many have suspected that nature can promote improved cognitive functioning and overall well- being, and these effects have recently been documented.

For thousands of years, wise people have recommended nature as a source of healing and wisdom. Shamans seek wilderness, yogis enter the forest, Christian Fathers retreat to the desert, and

American Indians go on nature vision quests. Their experience is that nature heals and calms, removes mental trivia, and reminds one of what really matters. Romantic and existential philosophers echoed similar claims, and the romantic poet William Wordsworth famously described the absence of such a healing connection:

Getting and spending, we lay waste our powers:

Little we see in Nature that is ours;

We have given our hearts away . . .

Yet today we are conducting a global experiment in which we increasingly spend our lives in artificial environments-- walled inside and divorced from nature. Within these nature-free settings, noise is often annoying, and lighting is often artificial, of low intensity (often less than 10% of the light intensity on sunny days), and composed of nonnatural spectra and rhythms. As the burgeoning field of environmental psychology demonstrates, the psychological costs of such settings can be wide-ranging. These costs include disruptions of mood, sleep, and diurnal rhythms. Cognitive costs include short-term impairment of attention and cognition as well as long-term reduced academic performance in the young and greater cognitive decline in the elderly. Further psychological difficulties occur in special populations such as those with Alzheimer's disease and postsurgical patients.

Media Immersion and Hyperreality In the last half century, a further artificial dimension has been added. Increasingly, we now spend hours each day immersed in a flood of multimedia stimuli, the neurological impact of which we are only beginning to understand. However, some researchers have already concluded that "the current explosion of digital technology not only is changing the way we live and communicate but also is rapidly and profoundly changing our brains". This is hardly surprising given that the average American spends several hours a day watching television and increasing amounts of time with digital media. As Thoreau lamented, people "have become the tools of their tools."

Fortunately, television and digital media can sometimes be beneficial. Multiple meta-analyses show that although aggressive television content can certainly foster negative attitudes and aggressive behavior, prosocial content can foster positive behavior such as altruism. Likewise, digital immersion can benefit certain psychological and social skills in children, as the massive Digital Youth Project demonstrated.

However, media immersion can also exact significant psychological and physical costs in both children and adults, and a novel vocabulary has emerged to describe multiple "technopathologies." Excessive media immersion, especially when combined with heavy work demands, can create psychological dysfunctions that include disorders of attention: continuous partial attention and attention deficit trait cognition: digital fog and techno-brain burnout overload: data smog and frazzing (frantic ineffectual multitasking) addiction: screen sucking and on-line compulsive disorder and, of course, techno-stress.

Yet the full implications of contemporary media and our divorce from nature may extend much further and cut far deeper than individual stress and pathology. There is an exploding literature on their social effects, and so powerful and pervasive is today's multimedia reality, that for philosophers such as Jean Baudrillard, it constitutes a hyperreality--a simulated lifeworld that seems more real than reality. So omnipresent are media-manufactured images and narratives, and so divorced are we from the direct events they portray, that we largely live in, believe in, and respond to this artificial hyperreal world rather than the natural world itself.

Evolutionary, Existential, and Clinical Concerns We have barely begun to research the many implications of artificial environments, new media, hyperreality, and our divorce from nature. However, the problems they may pose can be viewed in multiple ways. Biologically, we may be adapted to natural living systems and to seek them out. This is the biophilia hypothesis, and multiple new fields-- such as diverse schools of ecology, as well as evolutionary, environmental, and eco- psychologies--argue for an intimate and inescapable link between mental health and the natural environment. In existential terms, the concern is that "modern man-- by cutting himself off from nature has cut himself off from the roots of his own Being", thereby producing an existential and clinical condition generically described as nature-deficit disorder.

Clinicians harbor multiple concerns. Evolutionary and developmental perspectives suggest that children in environments far different from the natural settings in which we evolved, and to which we adapted, may suffer developmental disorders, with ADHD being one possible example. Likewise, evolutionary theory and cross- cultural research suggest that for adults, artificial environments and lifestyles may impair mental well-being and also foster or exacerbate psychopathologies such as depression.

Therapeutic Benefits of Nature Fortunately, natural settings can enhance both physical and mental health. In normal populations, these enhancements include greater cognitive, attentional, emotional, spiritual, and subjective well-being. Benefits also occur in special populations such as office workers, immigrants, hospital patients, and prisoners.

Nature also offers the gift of silence. Modern cities abound in strident sounds and noise pollution, and the days when Henry Thoreau could write of silence as a "universal refuge . . . a balm to our every chagrin" are long gone. Unfortunately, urban noise can exact significant cognitive, emotional, and psychosomatic tolls. These range, for example, from mere annoyance to attentional difficulties, sleep disturbances, and cardiovascular disease in adults and impaired language acquisition in children. By contrast, natural settings offer silence as well as natural sounds and stimuli that attention restoration theory and research suggest are restorative.

As yet, studies of specific psychotherapeutic benefits are limited, and the benefits are sometimes conflated with those of other therapeutic lifestyle factors. Though further research is clearly needed, immersion in nature does appear to reduce symptoms of stress, depression, and ADHD and to foster community benefits. In hospital rooms that offer views of natural settings, patients experience less pain and stress, have better mood and postsurgical outcomes, and are able to leave the hospital sooner. Consequently, nature may be "one of our most vital health resources". Given the global rush

of urbanization and technology, the need for mental health professionals to advocate for time in, and preservation of, natural settings will likely become increasingly important.

Relationships Of all the means which are procured by wisdom to ensure happiness throughout the whole of life, by far the most important is the acquisition of friends.

The idea that good relationships are central to both physical and mental well-being is an ancient theme, now supported by considerable research. Rich relationships reduce health risks ranging from the common cold to stroke, mortality, and multiple psychopathologies. On the positive side, good relationships are associated with enhanced happiness, quality of life, resilience, cognitive capacity, and perhaps even wisdom. Analyses of different domains of life indicate that quality of life is "dominated by the domain of intimacy" and that people with overt psychopathology have a lower quality of life "most particularly in the domain of intimacy".

These clinical observations can now be grounded in the emerging field of social neuroscience, which suggests that we are interdependent creatures, hardwired for empathy and relationship through, for example, the mirror neuron system. So powerful is interpersonal rapport that couples can mold one another both psychologically and physically. They may even come to look more alike, as resonant emotions sculpt their facial muscles into similar patterns--a process known as the Michelangelo phenomenon.

Not surprisingly, good relationships are crucial to psychotherapy. Multiple meta-analyses show that they account for approximately one third of outcome variance, significantly more than does the specific type of therapy, and that "the therapeutic relationship is the cornerstone" of effective therapy. As Irvin Yalom put it, the "paramount task is to build a relationship together that will itself become the agent of change." Ideally, therapeutic relationships then serve as bridges that enable patients to enhance life relationships with family, friends, and community.

The need may be greater than ever, because social isolation may be increasing and exacting significant individual and social costs. For example, considerable evidence suggests that, compared with Americans in previous decades, Americans today are spending less time with family and friends, have fewer intimate friends and confidants, and are less socially involved in civic groups and communities. However, there is debate over, for example, whether Internet social networking exacerbates or compensates for reduced direct interpersonal contact and over the methodology of some social surveys. Yet there is also widespread agreement that "the health risk of social isolation is comparable to the risks of smoking, high blood pressure and obesity.... [while] participation in group life can be like an inoculation against threats to mental and physical health". Beyond the individual physical and mental health costs of greater social isolation are public health costs. In "perhaps the most discussed social science article of the twentieth century", and in a subsequent widely read book, Bowling Alone: The Collapse and Revival of American Community, the political scientist Robert Putnam focused on the importance of social capital. Social capital is the sum benefit of the community connections and networks that link people and foster, for example, beneficial social engagement, support, trust, and reciprocity. Social capital seems positively and partly causally related to a wide range of social health measures--such as reduced poverty, crime, and drug

abuse--as well as increased physical and mental health in individuals. Yet considerable evidence suggests that social capital in the United States and other societies may have declined significantly in recent decades.

In short, relationships are of paramount importance to individual and collective well-being, yet the number and intimacy of relationships seem to be declining. Moreover, "the great majority of individuals seeking therapy have fundamental problems in their relationships". Clients' relationships are a major focus of, for example, interpersonal and some psychodynamic psychotherapies. Yet clients' interpersonal relationships often receive insufficient attention in clinical and training settings compared with intrapersonal and pharmacological factors. Focusing on enhancing the number and quality.

Relaxation and Stress Managements Chronic stressors can exact a major toll across multiple organ systems and levels. This toll extends from psychological to physiological to chemical (e.g., oxidative stress) to genomic expression (hence the new field of psychosocial genomics; Dusek et al., 2008). Even though stress is universal, few people are trained in managing it. In addition, humans now face an array of novel stressors for which there are no evolutionary or historical precedents. Many people therefore respond unskillfully or even self-destruc tively, aided and abetted by pervasive unhealthy influences such as advertising, media role models, and novel psychoactive drugs. Yet many skillful strategies for stress management are now available, ranging from lifestyle changes to psychotherapy to self-management skills. Beneficial TLCs include almost all those discussed in this article--especially exercise, recreation, relationships, and religious or spiritual involvement--and specific self-management skills can both complement and foster these TLCs.

Self-Management Skills Specific stress management skills include somatic, psychological, and contemplative approaches. Somatic skills span both ancient Oriental and contemporary Western techniques. The Chinese mindful movement practices of tai chi and qui gong are increasingly popular in the West, and research studies suggest they are associated with both physical and psychological benefits. A review of 15 randomized controlled trials of tai chi's effects on psychosocial well-being found significant benefits for the treatment of anxiety and depression but also noted the mixed quality of the trials.

Western self-management skills include mental approaches such as self-hypnosis and guided imagery (as well as somatic approaches, especially muscle relaxation therapies that center on systematically tightening and relaxing major muscle groups. By doing this, patients learn to identify and release muscle tension and eventually to self- regulate both muscle and psychological tensions. Muscle relaxation skills are widely used for the treatment of anxiety disorders, including panic and generalized anxiety disorders, and meta-analyses reveal medium to large effect sizes).

Contemplative skills such as meditation and yoga are now practiced by millions of people in the United States and by hundreds of millions worldwide. Concomitantly, an explosion of meditation research has demonstrated a wider array of effects--psychological, therapeutic, neural, physiological, biochemical, and chromosomal-- than are associated with any other psychotherapy.

Considerable research suggests that meditation can ameliorate a wide array of (especially stress-related) psychological and psychosomatic disorders in both adults and children. Multiple studies, including meta-analyses, show that meditation can reduce stress measures in both clinical and normal populations. Partially responsive psychosomatic disorders include, for example, cardiovascular hypertension and hypercholesterolemia, hormonal disorders such as primary dysmenorrhea and Type 2 diabetes, asthma, and chronic pain. Responsive psychological difficulties include, among others, insomnia, anxiety, depressive, eating, and borderline personality disorders.

Meditation can also be beneficial when combined with other therapies. The best known combinations are dialectical behavior therapy (primarily used for borderline personality disorder), mindfulness-based stress reduction, and mindfulness-based cognitive therapy. A meta-analysis of mindfulness-based therapies found large effect sizes for anxiety and depressive symptoms of 0.95 and 0.97, respectively, and therapeutic gains were maintained at follow-up.

It is now clear that meditation, either alone or in combination with other therapies, can be beneficial for both normal and multiple clinical populations. However, it is less clear how different meditation practices compare or how meditation compares with other therapies and selfregulation strategies such as relaxation, feedback, and selfhypnosis.

Yoga may also be helpful for stress and mood disorders. However, studies on yoga are fewer, and reviews have drawn cautious conclusions.

In addition to its benefits for relaxation and stress management, meditation may also enhance measures of psychological capacities, health, and maturity in both patients and nonpatients. Particularly important to health care professionals are findings that meditation can enhance valued caregiver qualities such as empathy, sensitivity, emotional stability, and psychological maturity while reducing distress and burnout. On the cognitive side, studies suggest that meditation can enhance some measures of cognition and may reduce age-related cognitive losses and corresponding brain shrinkage. The universality of stress, as well as the multiple benefits of both lifestyle changes and self-regulation skills for managing stress, suggests that these TLCs and self-regulation skills deserve to be central components of health professionals' training, personal and professional practice, and public outreach.

Religious and Spiritual Involvement Religious and spiritual concerns are vitally important to most people and most patients. Some 90% of the world's population engages in religious or spiritual practices; these practices are a major means of coping with stress and illness; and most patients say that they would welcome their health professionals' inquiring about religious issues. Yet few health professionals do. This lack of attention may be unfortunate given the prevalence and importance of religious and spiritual practices, their many influences on lifestyle and health, their impact on therapeutic relationships and effectiveness, and the deep existential issues they open.

Considerable research suggests a complex but usually beneficial relationship between religious involvement and mental health. The most massive review to date found statistically significant positive associations in 476 of 724 quantitative studies. In general, religious or spiritual involvement

is most likely to be beneficial when it centers on themes such as love and forgiveness and is likely to be less helpful or even harmful to mental health when themes of punishment and guilt predominate.

Benefits span an array of health measures. Mental health benefits include enhanced psychological, relational, and marital well-being, as well as reduced rates of disorders such as anxiety, depression, substance abuse, and suicide. For physical health, religious involvement seems beneficially related to both specific disorders such as hypertension and to nonspecific mortality rates. Strikingly, those who attend religious services at least weekly tend to live approximately seven years longer than those who do not, even when factors such as baseline health and health behaviors are statistically controlled. Important mediating and contributory factors likely include service to others and especially social support. Contemplative practices such as meditation offer further psychological, somatic, and spiritual benefits.

Religion, Spirituality, and Psychological Development It is important for mental health professionals to recognize that there are multiple levels of religious development. These levels range from preconventional to conventional to postconventional (or from prepersonal to personal to transpersonal) and are associated with extremely different kinds of religious faith, practice, behavior, and institutions.

For example, consider the developmental stages of religious faith. At the preconventional level, mythic-literal faith involves an unreflective, literal acceptance of culturally provided beliefs. At the synthetic-conventional level, people begin to create their own individual, but still largely unreflective, synthesis of diverse conventional beliefs. At later postconventional stages, exemplified by conjunctive and universalizing faith, individuals critically reflect on conventional assumptions, open themselves to multiple perspectives, confront paradoxes, and extend their care and concern to all peoples.

When developmental differences go unrecognized, problems ensue. For example, the views of one level are taken as normative, and those at this level tend to assume that people at other levels are mistaken, misguided, malevolent, or disturbed. Many contemporary religious and cultural conflicts appear to reflect these kinds of cross-level misunderstandings.

This developmental perspective brings new clarity to many religious and spiritual issues. For example, it makes clear that religions are not only culturally diverse but also developmentally diverse, and that mental health professionals need to be sensitive to both kinds of diversity. Religion can be an expression of immaturity, conventional maturity, and postconventional maturity, and of corresponding motives and concerns ranging from egocentric to ethnocentric to worldcentric. Interpretations that view religion as, for example, always regressive or always transcendental invariably overlook this developmental perspective. Examples of reductionistic interpretations that view religion as necessarily regressive or pathological include the writings of the so called "neoatheists," such as the recent extremely popular books The God Delusion, The End of Faith, and God Is Not Great, all of which are ignorant of developmental research. Unfortunately, the widespread failure to recognize developmental differences--in faith, morality, values, ego, worldview, and more-- and their far-reaching implications for religion and multiple other areas of

life seems a significant factor underlying many contemporary cultural conflicts.

Of course, religious behavior can sometimes be regressive or pathological. However, religious behavior can also both express and foster healthy, mature, and even exceptionally mature development. In fact, a classic goal of spiritual practices such as meditation is to foster postconventional development through, for example, bhavana (mental cultivation) in Buddhism and lien-hsin (refining the mind) in Taoism. Contemporary research and meta-analysis are supportive, because meditators tend to score higher on measures of ego, moral, and cognitive development as well as self-actualization, coping skills and defenses, and states and stages of consciousness. Ideally, religious and spiritual traditions offer both legitimacy (support for people's current level of psychological and faith development) as well as authenticity (support for maturation beyond current levels. Given the significance of religious and spiritual involvement, it seems important for therapists to be familiar with developmental and other key issues and, where appropriate, to inquire about and support healthy involvement in this domain.

Contribution and Service From ancient times, service and contribution to others have been regarded as virtues that can benefit both giver and receiver. The world's major spiritual traditions emphasize that, when viewed correctly, service is not necessarily a sacrifice but rather can foster qualities that serve the giver--such as happiness, mental health, and spiritual maturity. Altruism is said to reduce unhealthy mental qualities such as greed, jealousy, and egocentricity while enhancing healthy qualities such as love, joy, and generosity. The benefits of service are also said to extend to healing, such that healing oneself and others can be intimately linked. Multiple myths and healing traditions describe wounded healers, people who by virtue of their own illness learn to heal others and may thereby be healed themselves.

In our own time, both theory and research point to correlations between altruism and measures of psychological and physical health. Multiple studies, including those that control for prior health factors, suggest that people who volunteer more are psychologically happier and healthier, are physically healthier, and may even live longer. The so-called "paradox of happiness" is that spending one's time and resources on others can make one happier.

Altruists of all ages may experience a "helpers' high" (Post, Underwood, Schloss, & Hulbert, 2002). Even required community service for adolescents seems to effect long-term positive psychological changes, and even mandated monetary donations can make college students happier than spending the money on themselves (Dunn, Aknin, & Norton, 2008). Erik Erikson (1959) famously suggested that "generativity" (care and concern for others, and especially for future generations) may be a hallmark of successful maturation. Moreover, altruism has a positive social contagion or multiplier effect. For example, cooperative behaviors cascade through social networks to induce further cooperation in others (J. H. Fowler & Christakis, 2010), and at the community level, service is a key contributor to social capital (Putnam, 2000).

In summary, considerable research shows positive relationships between altruistic behavior and multiple measures of psychological, physical, and social well-being. However, there are important qualifiers. Major exceptions include the caretaker burnout experienced by overwhelmed family

members caring for a demented spouse or parent. Furthermore, the kind of motivation powering the prosocial behavior affects outcome. Whereas service motivated by pleasure in helping is associated with multiple positive measures (such as positive affect, self-esteem, self-actualization, and life satisfaction), this association may not hold when service is driven by a sense of internal pressure, duty, and obligation.

Psychotherapists repeatedly rediscover the healing potentials of altruistic behavior for both their patients and themselves. Alfred Adler emphasized the benefits of "social interest," and helping other group members contributes to the effectiveness of group therapy and support groups such as Alcoholics Anonymous. Likewise, therapists often report that helping their patients can enhance their own well- being. Wisely perceived, altruism is not self-sacrifice but rather enlightened self-interest. As the Dalai Lama put it, "If you're going to be selfish, be wisely selfish--which means to love and serve others, since love and service to others bring rewards to oneself that otherwise would be unachievable".

These benefits of altruism hold major implications for our understanding of health, lifestyle, and therapy. On the basis of their research findings, Brown, Nesse, Vinokur, and Smithwrote an article titled "Providing Social Support May Be More Beneficial Than Receiving It" and concluded that interventions "designed to help people feel supported may need to be redesigned so that the emphasis is on what people do to help others" (p. 326). Other researchers quipped, "If giving weren't free, pharmaceutical companies could herald the discoveries of a stupendous new drug called 'Give Back'-- instead of 'Prozac'". Contribution and service to others have long been considered central elements of a life well lived. Now they can also be considered central elements of a healthy life.

Discussion A culture's technology has far-reaching effects on people's psychology and lifestyles, and modern technology is now affecting our psychology, biology, society, and lifestyles in ways we are only beginning to comprehend. Moreover, technological innovations and their lifestyle effects are changing "more quickly than we know how to change ourselves". Many of the resultant costs are doubtless as yet unrecognized, and this raises a disconcerting question: Could some of our patients be "canaries in the coal mine," warning us of ways of life that may exact a toll on us all? This is a question that health professionals will need to confront increasingly as technological, environmental, and lifestyle changes accelerate.

Interactions Among Therapeutic Lifestyle Factors Fortunately, individual TLCs appear to counter many medical and psychological complications of contemporary pathogenic lifestyles. This raises a hopeful possibility: Might multiple TLCs be even more effective? There is evidence for this possibility in both animal studies and clinical medicine. For example, physical activity increases neuronogenesis in the rat hippocampus. However, the effect is maximal only when the animals are exposed to a rich social environment rather than living in isolation (Stranahan, Khalil, & Gould, 2006). Similarly, in his program to reverse coronary arteriosclerosis, Dean Ornish employed four TLCs-- exercise, vegetarian diet, relaxation and stress management, and social support. Each proved beneficial, and the effects were additive. Might this also be true for psychological disorders? Quite possibly, but as yet we have no clear answer.

Difficulties of Implementing Therapeutic Lifestyle Changes Given the many advantages of TLCs, why have mental health professionals been so slow to adopt them? The reasons involve patients, therapists, and society. Effective public health programs will therefore need to address all of them.

For patients, TLCs can require considerable and sustained effort, and many patients feel unable or unwilling to tackle them. Patients often have little social support, little understanding of causal lifestyle factors, and a passive expectation that healing comes from an outside authority or a pill. Societally, whole industries are geared toward encouraging unhealthy choices. Patients contend with a daily barrage of psychologically sophisticated advertisements encouraging them, for example, to consume alcohol, nicotine, and fast food in the neverending search for what the food industry calls the "bliss point" of "eatertainment" through "hypereating". Unfortunately, one can never get enough of what one does not really want, but one can certainly ruin one's health and life trying.

Therapists also face challenges. The first is simply to become familiar with the large literature on TLCs. The second is a professional bias toward pharmacological and formal psychotherapeutic interventions. In addition, fostering patients' TLCs can be time intensive, can demand considerable therapeutic skill, and is not well reimbursed. Therapists may also harbor negative expectations (not without some justification) that patients will not maintain the necessary changes. However, it is crucial to be aware of the Rosenthal effect: the self-fulfilling power of interpersonal expectations. Finally, cognitive dissonance may be at work when therapists' own lifestyles are unhealthy.

Taken together, these therapist beliefs and biases may constitute a variant of what is called professional deformation. This is a harmful distortion of psychological processes such as cognition and perception that is produced by professional practice and pressures. As long ago as 1915, a sociologist observed that "the continued performance of a certain profession or trade creates in the individual a deformation of the reasoning process. . . . such deformation is largely a matter of adaptation to environment". Professional deformation can be extreme. Consider, for example, the forced psychiatric hospitalization and drugging of Soviet dissidents by Soviet mental health professionals who believed that the counterconventional beliefs of these "patients" were diagnostic of "sluggish schizophrenia".

However, more subtle forms of professional deformation may be more pervasive and more difficult to recognize. The mental health system's current pharmacological emphasis--at the cost of psychotherapeutic, social, and TLC interventions--may be one example. This pharmacological bias is heavily promoted by the pharmaceutical industry, and Marcia Angell, former editor of the New England Journal of Medicine, concluded that "one result of the intensive bias is that . . . even when changes in lifestyle would be more effective, doctors and their patients often believe that for every ailment and discontent there is a drug". An obvious question then becomes: Does the widespread underemphasis on lifestyle factors across mental health professions constitute a further example of professional deformation?

Are there additional therapeutic lifestyle factors? Certainly, and examples range from sleep hygiene to ethics, community engagement, and the moderating of television viewing, all of which have demonstrated mental health benefits.

Wide-scale adoption of TLCs will likely require widescale interventions that encompass educational, mental health, and public health systems. Political interventions may also be necessary, for example, to reduce children's exposure to media violence and unhealthy food advertising. Of course, these are major requirements. However, given the enormous mental, physical, social, and economic costs of contemporary lifestyles, such interventions may be essential. In the 21st century, therapeutic lifestyles may need to be a central focus of mental, medical, and public health."

42) A standard resource book on 'Mental Health' has been published by W.H.O. Chapter 1 of the book covers Five main areas as under: -

> "2. The interface between mental health law and mental health policy Mental health law represents an important means of re-enforcing the goals and objectives of policy. When comprehensive and well conceived, a mental health policy will address critical issues such as:

x establishment of high quality mental health facilities and services;

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x       access to quality mental health care;
x       protection of human rights;
x       patients' right to treatment;
x       development of robust procedural protections;
x       integration of persons with mental disorders into the community;
        and
x       promotion of mental health throughout society.
x
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Mental health law or other legally prescribed mechanisms, such as regulations or declarations, can help to achieve these goals by providing a legal framework for implementation and enforcement.

Conversely, legislation can be used as a framework for policy development. It can establish a system of enforceable rights that protects persons with mental disorders from discrimination and other human rights violations by government and private entities, and guarantees fair and equal treatment in all areas of life. Legislation can set minimum qualifications and skills for accreditation of mental health professionals and minimum staffing standards for accreditation of mental health facilities. Additionally, it can create affirmative obligations to improve access to mental health care, treatment and support. Legal protections may be extended through laws of general applicability or through specialized legislation specifically targeted at persons with mental disorders.

Policy-makers within government (at national, regional and district levels), the private sector and civil society, who may have been reluctant to pursue changes to the status quo, may be obliged to do so based on a legislative mandate; others who may have been restricted from developing progressive policies may be enabled through legislative changes. For example, legal provisions that prohibit discrimination against persons with mental disorders may induce policy-makers to develop new policies for protection against discrimination, while a law promoting community treatment as an alternative to involuntary hospital admissions may provide policy- makers with much greater flexibility to create and implement new community-based programmes.

By contrast, mental health law can also have the opposite effect, preventing the implementation of new mental health policies by virtue of an existing legislative framework. Laws can inhibit policy objectives by imposing requirements that do not allow for the desired policy modifications or effectively prevent such modifications. For instance, in many countries, laws that do not include provisions related to community treatment have hindered the implementation of community treatment policies for persons with mental disorders.

Additionally, policy may be hindered even under permissive legal structures due to a lack of enforcement powers.

Policy and legislation are two complementary approaches for improving mental health care and services; but unless there is also political will, adequate resources, appropriately functioning institutions, community support services and well trained personnel, the best policy and legislation will be of little significance. For instance, the community integration legislation mentioned above will not succeed if the resources provided are insufficient for developing community-based facilities, services and rehabilitation programmes. While legislation can provide an impetus for the creation of such facilities, services and programmes, legislators and policy-makers need to follow through in order to realize the full benefits of community integration efforts. All mental health policies require political support to ensure that legislation is implemented correctly. Political support is also needed to amend legislation after it has been passed to correct any unintended situations that may undermine policy objectives.

In summary, mental health law and mental health policy are closely related. Mental health law can influence the development and implementation of policy, while the reverse is similarly true. Mental health policy relies on the legal framework to achieve its goals, and protect the rights and improve the lives of persons affected by mental disorders.

3. Protecting, promoting and improving rights through mental health legislation In accordance with the objectives of the United Nations (UN) Charter and international agreements, a fundamental basis for mental health legislation is human rights. Key rights and principles include equality and non-discrimination, the right to privacy and individual autonomy, freedom from inhuman and degrading treatment, the principle of the least restrictive environment, and the rights to information and participation. Mental health legislation is a powerful tool for codifying and consolidating these fundamental values and principles. Equally, being unable to access care is an infringement of a person's right to health, and access can be included in legislation. This section presents a number of interrelated reasons why mental health legislation is necessary, with special attention to the themes of human rights and access to services.

3.1 Discrimination and mental health Legislation is needed to prevent discrimination against persons with mental disorders. Commonly, discrimination takes many forms, affects several fundamental areas of life and (whether overt or inadvertent) is pervasive. Discrimination may impact on a person's access to adequate treatment and care as well as other areas of life, including employment, education and shelter. The inability to integrate properly into society as a consequence of these limitations can increase the isolation experienced by an individual, which can, in turn,

aggravate the mental disorder. Policies that increase or ignore the stigma associated with mental disorder may exacerbate this discrimination.

The government itself can discriminate by excluding persons with mental disorders from many aspects of citizenship such as voting, driving, owning and using property, having rights to sexual reproduction and marriage, and gaining access to the courts. In many cases, the laws do not actively discriminate against people with mental disorders, but place improper or unnecessary barriers or burdens on them. For example, while a country's labour laws may protect a person against indiscriminate dismissal, there is no compulsion to temporarily move a person to a less stressful position, should they require some respite to recover from a relapse of their mental condition. The result may be that the person makes mistakes or fails to complete the work, and is therefore dismissed on the basis of incompetence and inability to carry out allocated functions. Discrimination may also take place against people with no mental disorder at all if they are mistakenly viewed as having a mental disorder or if they once experienced a mental disorder earlier in life. Thus protections against discrimination under international law go much further than simply outlawing laws that explicitly or purposefully exclude or deny opportunities to people with disabilities; they also address legislation that has the effect of denying rights and freedoms (see, for example, Article 26 of the International Covenant on Civil and Political Rights of the United Nations).

3.2 Violations of human rights One of the most important reasons why human-rights-oriented mental health legislation is vital is because of past and ongoing violations of these rights. Some members of the public, certain health authorities and even some health workers have, at different times and in different places, violated - and in some instances continue to violate - the rights of people with mental disorders in a blatant and extremely abusive manner. In many societies, the lives of people with mental disorders are extremely harsh. Economic marginalization is a partial explanation for this; however, discrimination and absence of legal protections against improper and abusive treatment are important contributors. People with mental disorders are often deprived of their liberty for prolonged periods of time without legal process (though sometimes also with unfair legal process, for example, where detention is allowed without strict time frames or periodic reports). They are often subjected to forced labour, neglected in harsh institutional environments and deprived of basic health care. They are also exposed to torture or other cruel, inhumane or degrading treatment, including sexual exploitation and physical abuse, often in psychiatric institutions.

Furthermore, some people are admitted to and treated in mental health facilities where they frequently remain for life against their will. Issues concerning consent for admission and treatment are ignored, and independent assessments of capacity are not always undertaken. This means that many people may be compulsorily kept in institutions, despite having the capacity to make decisions regarding their future. On the other hand, where there are shortages of hospital beds, the failure to admit people who need inpatient treatment, or their premature discharge (which can lead to high readmission rates and sometimes even death), also constitutes a violation of their right to receive treatment.

People with mental disorders are vulnerable to violations both inside and outside the institutional context. Even within their own communities and within their own families, for example, there are cases of people being locked up in confined spaces, chained to trees and sexually abused.

3.3 Autonomy and liberty An important reason for developing mental health legislation is to protect people's autonomy and liberty. Legislation can do this in a number of ways. For example, it can:

x Promote autonomy by ensuring mental health services are accessible for people who wish to use such services; x Set clear, objective criteria for involuntary hospital admissions, and, as far as possible, promote voluntary admissions; x Provide specific procedural protections for involuntarily committed persons, such as the right to review and appeal compulsory treatment or hospital admission decisions;

x Require that no person shall be subject to involuntary hospitalization when an alternative is feasible; x Prevent inappropriate restrictions on autonomy and liberty within hospitals themselves (e.g. rights to freedom of association, confidentiality and having a say in treatment plans can be protected); and x Protect liberty and autonomy in civil and political life through, for example, entrenching in law the right to vote and the right to various freedoms that other citizens enjoy.

In addition, legislation can allow people with mental disorders, their relatives or other designated representatives to participate in treatment planning and other decisions as a protector and advocate. While most relatives will act in the best interests of a member of their family with a mental disorder, in those situations where relatives are not closely involved with patients, or have poor judgement or a conflict of interest, it may not be appropriate to allow the family member to participate in key decisions, or even to have access to confidential information about the person. The law, therefore, should balance empowering family members to safeguard the person's rights with checks on relatives who may have ulterior motives or poor judgement.

Persons with mental disorders are also at times subject to violence. Although public perceptions of such people are often of violent individuals who are a danger to others, the reality is that they are more often the victims than the perpetrators. Sometimes, however, there may be an apparent conflict between the individual's right to autonomy and society's obligation to prevent harm to all persons. This situation could arise when persons with a mental disorder pose a risk to themselves and to others due to an impairment of their decision-making capacity and to behavioural disturbances associated with the mental disorders. In these circumstances, legislation should take into account the individuals' right to liberty and their right to make decisions regarding their own health, as well as society's obligations to protect persons unable to care for themselves, to protect all persons from harm, and to preserve the health of the entire population. This complex set of variables demands close consideration when developing legislation, and wisdom in its implementation.

3.4 Rights for mentally ill offenders The need to be legally fair to people who have committed an apparent crime because of a mental disorder, and to prevent the abuse of people with mental disorders who become involved in the criminal justice system, are further reasons why mental

health legislation is essential. Most statutes acknowledge that people who did not have control of their actions due to a mental disorder at the time of the offence, or who are unable to understand and participate in court proceedings due to mental illness, require procedural safeguards at the time of trial and sentencing. But how these individuals are handled and treated is often not addressed in the legislation or, if it is, it is done poorly, leading to abuse of human rights.

Mental health legislation can lay down procedures for dealing with people with mental disorders at various stages of the legal process.

3.5 Promoting access to mental health care and community integration The fundamental right to health care, including mental health care, is highlighted in a number of international covenants and standards. However, mental health services in many parts of the world are poorly funded, inadequate and not easily accessible to persons in need. Some countries have hardly any services, while in others services are available to only certain segments of the population. Mental disorders sometimes affect people's ability to make decisions regarding their health and behaviour, resulting in further difficulties in seeking and accepting needed treatment.

Legislation can ensure that appropriate care and treatment are provided by health services and other social welfare services, when and where necessary. It can help make mental health services more accessible, acceptable and of adequate quality, thus giving persons with mental disorders better opportunities to exercise their right to receive appropriate treatment. For example, legislation and/or accompanying regulations can include a statement of responsibility for:

x Developing and maintaining community-based services; x Integrating mental health services into primary health care; x Integrating mental health services with other social services; x Providing care to people who are unable to make health decisions due to their mental disorder;

x Establishing minimum requirements for the content, scope and nature of services;

x Assuring the coordination of various kinds of services; x Developing staffing and human resource standards; x Establishing quality of care standards and quality control mechanisms; and x Assuring the protection of individual rights and promoting advocacy activities among mental health users.

Many progressive mental health policies have sought to increase opportunities for persons with mental disorders to live fulfilling lives in the community. Legislation can foster this if it: i) prevents inappropriate institutionalization; and ii) provides for appropriate facilities, services, programmes, personnel, protections and opportunities to allow persons with mental disorders to thrive in the community.

Legislation can also play an important role in ensuring that a person suffering from a mental disorder can participate in the community. Prerequisites for such participation include access to treatment and care, a supportive environment, housing, rehabilitative services (e.g. occupational and life skills training), employment, non- discrimination and equality, and civil and political rights (e.g. right to vote, drive and access courts). All of these community services and protections can be

implemented through legislation.

Of course, the level of services that can be made available will depend on a country's resources. Legislation that contains unenforceable and unrealistic provisions will remain ineffective and impossible to implement. Moreover, mental health services often lag behind other health care services, or are not provided in an appropriate or cost-effective manner. Legislation can make a big difference in securing their parity with other health care services, and in ensuring that what is provided is appropriate to people's needs.

Provision of medical insurance is another area where legislation can play a facilitating role. In many countries, medical insurance schemes exclude payment for mental health care or offer lower levels of coverage for shorter periods of time. This violates the principle of accessibility by being discriminatory and creating economic barriers to accessing mental health services. By including provisions concerning medical insurance, legislation can ensure that people with mental disorders are able to afford the treatment they require.

4. Separate versus integrated legislation on mental health There are different ways of approaching mental health legislation. In some countries there is no separate mental health legislation, and provisions related to mental health are inserted into other relevant legislation. For example, issues concerning mental health may be incorporated into general health, employment, housing or criminal justice legislation. At the other end of the spectrum, some countries have consolidated mental health legislation, whereby all issues of relevance to mental health are incorporated into a single law. Many countries have combined these approaches, and thus have integrated components as well as a specific mental health law.

There are advantages and disadvantages to each of these approaches. Consolidated legislation has the ease of enactment and adoption, without the need for multiple amendments to existing laws. The process of drafting, adopting and implementing consolidated legislation also provides a good opportunity to raise public awareness about mental disorders and educate policymakers and the public about human rights issues, stigma and discrimination. However, consolidated legislation emphasizes segregation of mental health and persons with mental disorders; hence, it can potentially reinforce stigma and prejudice against persons with mental disorders.

The advantages of inserting provisions relating to mental disorders into non-specific relevant legislation are that it reduces stigma and emphasizes community integration of those with mental disorders. Also, by virtue of being part of legislation that benefits a much wider constituency, it increases the chances that laws enacted for the benefit of those with mental disorders are actually put into practice. Among the main disadvantages associated with "dispersed" legislation is the difficulty in ensuring coverage of all legislative aspects relevant to persons with mental disorders; procedural processes aimed at protecting the human rights of people with mental disorders can be quite detailed and complex and may be inappropriate in legislation other than a specific mental health law. Furthermore, it requires more legislative time because of the need for multiple amendments to existing legislation.

There is little evidence to show that one approach is better than the other. A combined approach, involving the incorporation of mental health issues into other legislation as well as having a specific mental health law, is most likely to address the complexity of needs of persons with mental disorders. However, this decision will depend on countries' circumstances.

When drafting a consolidated mental health legislation, other laws (e.g. criminal justice, welfare, education) will also need to be amended in order to ensure that provisions of all relevant laws are in line with one another and do not contradict each other.

5. Regulations, service orders, ministerial decrees Mental health legislation should not be viewed as an event, but as an ongoing process that evolves with time. This necessarily means that legislation is reviewed, revised and amended in the light of advances in care, treatment and rehabilitation of mental disorders, and improvements in service development and delivery. It is difficult to specify the frequency with which mental health legislation should be amended; however, where resources allow, a 5- to 10-year period for considering amendments would appear appropriate.

In reality, frequent amendments to legislation are difficult due to the length of time and the financial costs of an amendment process and the need to consult all stakeholders before changing the law. One solution is to make provisions in the legislation for the establishment of regulations for particular actions that are likely to need constant modifications. Specifics are not written into the legislation but, instead, provision is made in the statute for what can be regulated, and the process for establishing and reviewing regulations. For example, in South African law, rules for accreditation of mental health professionals are not specified in the legislation, but are part of the regulations. Legislation specifies who is responsible for framing the regulations and the broad principles upon which these regulations are based. The advantage of using regulations this way is that it allows for frequent modifications to the accreditation rules without requiring a lengthy process of amending primary legislation. Regulations can thus provide flexibility to mental health legislation.

Other alternatives to regulations in some countries are the use of executive decrees and service orders. These are often short- to medium-term solutions where, for various reasons, interim interventions are necessary. For example, in Pakistan, an ordinance was issued in 2001 amending the mental health law, even though the National Assembly and the Senate had been suspended under a Proclamation of Emergency. The preamble to the ordinance stated that circumstances existed which made it necessary to "take immediate action" (Pakistan Ordinance No. VIII of 2001). This was required and deemed desirable by most people concerned with mental health, given the country's existing outdated law. Nonetheless, the issuance of such an ordinance needs to be ratified by the elected body within a specified time frame, as is the case in Pakistan, to ensure that potentially retrogressive and/or undemocratic legislation does not persist.

6. Key international and regional human rights instruments related to the rights of people with mental disorders The requirements of international human rights law, including both UN and regional human rights instruments, should form the framework for drafting national legislation that concerns people with mental disorders or regulates mental health and social service systems. International human rights documents broadly fall into two categories: those which legally bind

States that have ratified such conventions, and those referred to as international human rights "standards", which are considered guidelines enshrined in international declarations, resolutions or recommendations, issued mainly by international bodies. Examples of the first are international human rights conventions such as the International Covenant on Civil and Political Rights (ICCPR, 1966) and the International Covenant on Economic, Social and Cultural Rights (ICESR, 1966). The second category, which includes UN General Assembly Resolutions such as Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles, 1991), while not legally binding, can and should influence legislation in countries, since they represent a consensus of international opinion.

6.1 International and regional human rights instruments There is a widespread misconception that because the human rights instruments relating specifically to mental health and disability are non-binding resolutions, rather than obligatory conventions, mental health legislation is therefore subject only to the domestic discretion of governments. This is not true, as governments are under obligation, under international human rights law, to ensure that their policies and practices conform to binding international human rights law - and this includes the protection of persons with mental disorders.

Treaty monitoring bodies at the international and regional levels have the role of overseeing and monitoring compliance by States that have ratified international human rights treaties. Governments that ratify a treaty agree to report regularly on the steps they have taken to implement that treaty at the domestic level through changes in legislation, policy and practice. Nongovernmental organizations (NGOs) can also submit information to support the work of monitoring bodies. Treaty monitoring bodies consider the reports, taking into account any information submitted by NGOs and other competent bodies, and publish their recommendations and suggestions in "concluding observations", which may include a determination that a government has not met its obligations under the treaty. The international and regional supervisory and reporting process thus provides an opportunity to educate the public about a specialized area of rights. This process can be a powerful way to pressure governments to uphold convention-based rights.

The treaty bodies of the European and Inter-American human rights system have also established individual complaints mechanisms, which provide the opportunity for individual victims of human rights violations to have their cases heard and to seek reparations from their governments.

This section provides an overview of some of the key provisions of international and regional human rights instruments that relate to the rights of persons with mental disorders.

6.1.1 International Bill of Rights The Universal Declaration of Human Rights (1948), along with the International Covenant on Civil and Political Rights (ICCPR, 1966) and the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966), together make up what is known as the "International Bill of Rights". Article 1 of the Universal Declaration of Human Rights, adopted by the United Nations in 1948, provides that all people are free and equal in rights and dignity. Thus people with mental disorders are also entitled to the enjoyment and protection of their fundamental

human rights.

In 1996, the Committee on Economic, Social and Cultural Rights adopted General Comment 5, detailing the application of the International Covenant on Economic, Social and Cultural Rights (ICESCR) with regard to people with mental and physical disabilities. General Comments, which are produced by human rights oversight bodies, are an important source of interpretation of the articles of human rights conventions. General comments are non-binding, but they represent the official view as to the proper interpretation of the convention by the human rights oversight body.

The UN Human Rights Committee, established to monitor the ICCPR, has yet to issue a general comment specifically on the rights of persons with mental disorders. It has issued General Comment 18, which defines protection against discrimination against people with disabilities under Article 26.

A fundamental human rights obligation in all three instruments is the protection against discrimination. Furthermore, General Comment 5 specifies that the right to health includes the right to access rehabilitation services. This also implies a right to access and benefit from services that enhance autonomy. The right to dignity is also protected under General Comment 5 of the ICESCR as well as the ICCPR. Other important rights specifically protected in the International Bill of Rights include the right to community integration, the right to reasonable accommodation (General Comment 5 ICESCR), the right to liberty and security of person (Article 9 ICCPR) and the need for affirmative action to protect the rights of persons with disabilities, which includes persons with mental disorders.

Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) establishes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The right to health is also recognized in other international conventions, such as Article 5(e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965, Articles 11.1(f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women of 1979, and Article 24 of the Convention on the Rights of the Child of 1989. Several regional human rights instruments also recognize the right to health, such as the European Social Charter of 1996, as revised (Art. 11), the African Charter on Human and Peoples' Rights of 1981 (Art. 16), and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988 (Art. 10).

General Comment 14 of the Committee on Economic, Social and Cultural Rights aims to assist countries in implementation of Article 12 of ICESCR. General Comment 14 specifies that the right to health contains both freedoms and entitlements, which include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. Entitlements also include the right to a system of health protection that provides people with equality of opportunity to enjoy the highest attainable level of health. According to the Committee, the right to health includes the following interrelated elements:

(i) Availability, i.e. health care facilities and services have to be available in sufficient quantity.

(ii) Accessibility, which includes: · non-discrimination, i.e. health care and services should be available to all without any discrimination; · physical accessibility, i.e. health facilities and services should be within safe physical reach, particularly for disadvantaged and vulnerable populations; · economic accessibility, i.e. payments must be based on the principle of equity and affordable to all; and · information accessibility, i.e. the right to seek, receive and impart information and ideas concerning health issues.

(iii) Acceptability, i.e. health facilities and services must respect medical ethics and be culturally appropriate.

(iv) Quality, i.e. health facilities and services must be scientifically appropriate and of good quality.

General Comment 14 further states that the right to health imposes three types or levels of obligations on countries: the obligations to respect, protect and fulfil. The obligation to respect requires countries to refrain from interfering, directly or indirectly, with the enjoyment of the right to health. The obligation to protect requires countries to take measures to prevent third parties from interfering with the guarantees provided under Article 12. Finally, the obligation to fulfil contains obligations to facilitate, provide and promote. It requires countries to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health.

Article 7 of the ICCPR provides protection against torture, cruel, inhuman or degrading treatment, and it applies to medical institutions, especially institutions providing psychiatric care. The General Comment on Article 7 requires governments to "provide information on detentions in psychiatric hospitals, measures taken to prevent abuses, appeals process available to persons admitted to psychiatric institutions and complaints registered during the reporting period".

6.1.2 Other international conventions related to mental health The legally binding UN Convention on the Rights of the Child contains human rights provisions specifically relevant to children and adolescents. These include protection from all forms of physical and mental abuse; non-discrimination; the right to life, survival and development; the best interests of the child; and respect for the views of the child. A number of its articles are specifically relevant to mental health:

x Article 23 recognizes that children with mental or physical disabilities have the right to enjoy a full and decent life in conditions that ensure dignity, promote self-reliance and facilitate the child's active participation in the community.

x Article 25 recognizes the right to periodic review of treatment provided to children who are placed in institutions for the care, protection or treatment of physical or mental health. x Article 27 recognizes the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.

x Article 32 recognizes the right of children to be protected from performing any work that is likely to be hazardous or to interfere with their education, or to be harmful to their health or physical,

mental spiritual, moral or social development.

The UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984) is also relevant to those with mental disorders. Article 16, for example, makes States that are party to the Convention responsible for preventing acts of cruel, inhuman or degrading treatment or punishment.

In certain mental health institutions there are a vast number of examples that could constitute inhuman and degrading treatment. These include: lack of a safe and hygienic environment; lack of adequate food and clothing; lack of adequate heat or warm clothing; lack of adequate healthcare facilities to prevent the spread of contagious diseases; shortage of staff leading to practices whereby patients are required to perform maintenance labour without pay or in exchange for minor privileges; and systems of restraint that leave a person covered in his or her own urine or faeces or unable to stand up or move around freely for long periods of time.

The lack of financial or professional resources is not an excuse for inhuman and degrading treatment. Governments are required to provide adequate funding for basic needs and to protect the user against suffering that can be caused by a lack of food, inadequate clothing, improper staffing at an institution, lack of facilities for basic hygiene, or inadequate provision of an environment that is respectful of individual dignity.

There is no specific UN convention that addresses the special concerns of individuals with disabilities. However, on 28 November 2001, the United Nations General Assembly adopted a resolution calling for the creation of an ad hoc committee "to consider proposals for a comprehensive and integral international convention to protect and promote the rights and dignity of persons with disabilities". Work is currently under way to draft this convention. Persons with mental disorders would be among beneficiaries.

Apart from the various international systems for monitoring human rights, there are also a number of regional conventions for the protection of human rights. These are discussed briefly below."

43) This book has also dealt with the rights of families and carers of persons with mental disorders as under: -

"6. Rights of families and carers of persons with mental disorders The roles of families or other carers of people with mental disorders vary significantly from country to country and from culture to culture. Nonetheless, it is common for families and carers to assume many responsibilities for looking after persons with mental disorders. These include housing, clothing and feeding them, and ensuring that they remember to take their treatment. They also make sure these persons avail of care and rehabilitation programmes and assist them in following through with these. They often bear the brunt of the person's behaviour when he or she is ill or relapses, and it is usually the caregivers/family members that fundamentally love, care and worry about the person with the mental disorder. Sometimes they too become targets of stigma and discrimination. In some countries, families and carers also carry the legal responsibility for third-party liability arising from

actions of persons with mental disorders. The important role of families needs to be recognized in legislation.

Family members and carers need information about the illness and treatment plans to be better able to look after their ill relatives. Legislation should not arbitrarily refuse information merely on grounds of confidentiality - though the extent of an individual's right to confidentiality is likely to vary from culture to culture. For instance, in some cultures a patient's refusal to allow information to be released to family members or carers would need to be fully respected, while in others the family may be regarded as a unified, structured unit, and confidentiality may extend to culturally determined members of that family. It is likely, in these situations, that patients themselves are more accepting of the need to provide family members with information. In countries where there is more emphasis on the individual, as opposed to the family, it is more likely that the individual himself/herself may be less inclined to share information. Many variations and gradations are possible depending on culturally accepted practices. One position could be, for example, that family members who have ongoing responsibility for the care of a patient may receive some information required for the accomplishment of their supportive role in the patient's life, but not about other clinical or psychotherapeutic issues.

The right to confidentiality is not in dispute, however. In legislation, this right should be interpreted at the country level taking local cultural realities into account. In New Zealand, for example, under the Mental Health (Compulsory Assessment and Treatment) Amendment Act 1999, Section 2, " ... the legislative powers must be exercised or the proceedings conducted: a) with proper recognition of the importance and significance to the person of the person's ties with his or her family, whanau, hapu, iwi,1 and family group; b) with proper recognition of the contributions those ties make to the person's well-being; and c) with proper respect for the person's cultural and ethnic identity, language, and religious or ethical beliefs."

Families can play an important role in contributing to the formulation and implementation of a treatment plan for the patient, especially if the patient is incapable of doing it alone. The Mauritian law states that "the patient ... or next of kin may participate in the formulation of the treatment plan" (Mental Health Care Act, Act 24 of 1998, Mauritius).

Legislation can also ensure involvement of families in many aspects of mental health services and legal processes. For example, family members may have the right to appeal against involuntary admission and treatment decisions on behalf of their relative, if the latter lacks the capacity to do so himself/herself. Similarly, they may be able to apply for the discharge of a mentally ill offender. Countries may also choose to legislate that family groups should be represented on review bodies.

Legislation can also ensure that family members are involved in the development of mental health policy and legislation, as well as mental health service planning. In the United States, Public Law 99-660, the Health Care Quality Improvement Act (1986), mandates that each state should establish a "planning council" that must consist of at least 51% users and relatives. This planning council is to be responsible for the creation and ongoing monitoring of an annual statewide service system plan that must be approved by the council.

An exhaustive coverage of all situations where families' involvement becomes necessary is impossible. Instead, legislation can codify the principle that family members and family organizations are important stakeholders in the mental health system, and may therefore be represented in all forums and agencies where strategic decisions regarding mental health services are made."

44) Chapter 14.3 of the said Book deals with the protections for persons with mental disorders as under: - "14.3 Protections for persons with mental disorders Legislation may place restrictions on the activities of the police to ensure protection against unlawful arrest and detention of persons with mental disorders. These include the following:

14.3.1 Place of safety If a person is picked up by the police for causing public disorder that is suspected to be related to that person's mental health, police powers may be restricted to taking the person to a place of safety for an assessment of that person's condition by a qualified mental health practitioner. However, if the person is a known psychiatric patient, and does not appear to need treatment and care, the police may simply return the person to his or her home.

A "place of safety" could include a designated mental health facility, a private place (e.g. a psychiatrist's office) or other secure location. The police do not have the legal authority to detain the person in a prison facility (or in police custody) under these circumstances. However, where it is impossible to immediately take the person to a place of safety, such as may occur in some developing countries, the legislation should determine a short time frame in which the police may retain custody of a person suspected of having a mental disorder. Once the police have taken the person to a place of safety for assessment, the person is no longer considered to be in police custody and cannot be subsequently detained. Problems may occur with police powers of this type if the place of safety cannot (or will not) take the person in for assessment (e.g. because the place of safety does not have appropriate personnel available to conduct the assessment or does not have room for the person). Clearly, such situations indicate the need for the health sector to provide sufficient resources for mental health services. (see Chapter 2 subsection 4.1) If a person has been arrested for a criminal act, and the police have a reasonable suspicion that the person suffers from a mental disorder, such a person should be taken to a place of safety for assessment by a mental health professional. In situations where a person represents a danger to himself/herself or to others, he/she should be taken to a secure mental health facility for assessment. Following assessment, if no mental disorder is detected, the police would have the power to take the person back into detention or custody, if appropriate.

14.3.2 Treatment options Following the mental health assessment, if the person is deemed to require treatment he/she should be offered the opportunity to enter a programme (as an inpatient or outpatient, as appropriate). The full implications of his/her condition and the advantages and disadvantages of different treatment options should be explained to the patient. If the person refuses admission/treatment, he/she must be discharged unless the criteria for involuntary admission/treatment (described above) are met - in which case the relevant processes should be followed. Whether a person has been brought in by the police, a family member or anyone else, the due procedures for involuntary admission and treatment should be observed (see subsection 8.3

above).

14.3.3 Detention period The period of holding a person for an assessment should not be excessive. Legislation can mandate procedures requiring an assessment within a specified time period (e.g. 24-72 hours). If the assessment has not occurred by the end this period, the person should be released.

14.3.4 Prompt notification The police should promptly inform persons who are detained in their custody prior to being sent for an assessment as to why they are being detained and what will be happening to them. Under certain circumstances, a family member or other designated representative may also be notified of such a detention, with consent from the detainee.

14.3.5 Review of records Records of all incidents in which a person has been held on suspicion of mental disorder may be passed on to a review body or independent monitoring authority."

45) Chapter 16 of the said Book deals with additional substantive provisions affecting mental health as under: -

"16. Additional substantive provisions affecting mental health The welfare and well-being of people with mental disorders will be significantly enhanced by legislation that addresses the issues already discussed in this chapter: access; rights; voluntary and involuntary mental health care; review mechanisms and provisions related to mentally ill offenders. In addition, there are a number of other areas that are equally important in furthering mental health and well-being that can be effectively legislated, but which have been neglected historically. However, it is not possible to cover every issue in this Resource Book, and to discuss the full complexity of each point, but the following are pointers to areas that may be included in national legislation. In many countries these may be contained in legislation other than a specific mental health law. 16.1 Anti-discrimination legislation Legislation should protect people with mental disorders from discrimination. In many instances, countries have antidiscrimination, and even affirmative action, legislation for the protection of vulnerable populations, minorities and underprivileged groups. Such legislation can also be made applicable to persons with mental disorders by specifically including them as beneficiaries in the statute.

Alternatively, if general antidiscrimination legislation does not provide them with adequate protection, antidiscrimination provisions for people with mental disorders can be specifically included in mental health legislation. For example, in some countries people with mental disorders are not allowed to study in some schools, be in some public places, or travel in aeroplanes. Specific legislation may be required to rectify this.

As another legislative alternative, if, for example, a country has a Bill of Rights or other rights document, it should specify the grounds on which it is unlawful to discriminate, and this should encompass people with mental disorders. The New Zealand Bill of Rights Act (1990) for example, prohibits discrimination on the grounds of disability among other things.

16.2 General health care Persons with mental disorders may need legislative protection for their interaction with the general health care system, including access to treatment, quality of treatment offered, confidentiality, consent to treatment and access to information. Special clauses can be inserted into general health care legislation to emphasize the need for protection of vulnerable populations such as those with mental disorders and those who lack the capacity to make decisions for themselves.

16.3 Housing Legislation could incorporate provisions for giving persons with mental disorders priority in State housing schemes and subsidized housing schemes. For example, the Finland Mental Health Act states, "In addition to adequate treatment and services, a person suffering from a mental illness or some other mental disorder must be provided with a service flat and subsidized accommodation appropriate to the necessary medical or social rehabilitation as separately decreed" (Mental Health Act, No. 1116, 1990, Finland).

Such provisions may not be possible in some countries, but, at the very least, people with mental disorders should not be discriminated against in the allocation of housing. Legislation can also mandate governments to establish a range of housing facilities such as halfway homes and long-stay supported homes. Legislation should include provisions to prevent geographical segregation of persons with mental disorders. This may require specific provisions in appropriate legislation to prevent discrimination in location and allocation of housing for persons with mental disorders.

16.4 Employment Legislation could include provisions for the protection of persons with mental disorders from discrimination and exploitation in employment and equal employment opportunities. It could also promote reintegration into the workplace for people who have experienced a mental disorder, and ensure protection from dismissal from work solely on account of mental disorder. Legislation could also promote "reasonable accommodation" within the workplace, whereby employees with mental disorders are to be provided with a degree of flexibility in their working hours in order to be able to seek mental health treatment. For example, an employee could take time off to receive counselling and make up for that time later in the day.

The Rio Negro (Argentina) Act for the Promotion of Health Care and Social Services for Persons with Mental Illness (Act 2440, 1989) states that "the province shall ensure that appropriate measures to ensure access to work, which is a decisive factor in the recovery of persons with mental illness, are taken". It further decrees that a commission be established to examine the issue of work promotion, which will propose appropriate permanent measures to guarantee access to work for persons covered by the Act.

Laws can also contain provisions for establishing adequate funding of vocational rehabilitation programmes, provisions for preferential financing for income-generating activities by people with mental disorders residing in the community, and general affirmative action programmes to improve access to jobs and paid employment. Employment legislation can also provide protection to persons with mental disorders working in sheltered work schemes to ensure they are remunerated at a comparable rate to others and that there is no forced or coercive labour in such sheltered schemes.

Employment legislation that incorporates provisions concerning maternity leave, especially paid maternity leave, has proved effective as a health promotion tool in many countries. It allows new mothers to spend more time with their infants and facilitates the establishment of affective bonds, thus promoting good mental health for both infant and mother.

16.5 Social security The payment of disability grants can represent a huge benefit for people with mental disorders, and should be encouraged through legislation. Where pensions are provided, disability pensions for persons with mental disorders should be paid at a similar rate as pensions granted to persons with physical disabilities. The social security legislation needs to be flexible enough to allow people with mental disorders to get back into employment, especially part-time employment, without losing the benefits of their disability pension.

16.6 Civil issues Persons with mental disorders have the right to exercise all civil, political, economic, social and cultural rights as recognized in the Universal Declaration of Human Rights, The International Covenant on Economic, Social and Cultural Rights, and the International Covenant on Civil and Political Rights.

Some of the key rights (often denied to people with mental disorders) that need to be protected are mentioned below. This is not an exhaustive list; it merely illustrates the wide range of rights that may need to be protected. However, some of these rights are subject to limitations based on a person's capacity at a given point in time. Right to vote Right to marry Right to have children and to maintain parental rights Right to own property Right to work and employment Right to education Right to freedom of movement and choice of residence Right to health Right to a fair trial and due process of law Right to sign cheques and engage in other financial transactions Right to religious freedom and practice"

46) Chapter 17 of the Book deals with protections for vulnerable groups- minors, women, minorities and refugees as under: -

"17. Protections for vulnerable groups - minors, women, minorities and refugees The need for specific legislation for minors, women, minorities and refugees affected by mental disorders would probably be unnecessary if practice showed that these vulnerable groups received adequate and nondiscriminatory treatment and services. However, in reality these groups are discriminated against and serious inequities do exist. The extent and form of these problems vary from country to country, and the specific issues that different countries need to address through legislation also differ. Nonetheless, no country is immune to discrimination against vulnerable groups, and thus some aspects of the following sections will be relevant for all countries.

17.1 Minors Legislation protecting the human rights of children and adolescents should take account of their particular vulnerabilities. It should specifically aim to respect, protect and fulfil their rights, as laid out in the UN Convention on the Rights of the Child (1990) and other relevant international instruments.

In many countries there are no specialized mental health services for minors, and legislation can therefore play an important role in promoting the establishment of and access to such services.

Legislation should specifically discourage the involuntary admission of minors in mental health facilities. Hospitalization may be appropriate only when community-based alternatives are not available, are unlikely to be effective or have been tried and failed. If minors are placed in institutional settings, their living area must be separate from that of adults. The living environment in mental health facilities should be age-appropriate, and take into account the developmental needs of minors (e.g. provision of a play area, age- appropriate toys and recreational activities, access to schooling and education). While different countries will be able to fulfil these objectives to varying degrees, all countries should take positive steps towards realizing these objectives and consider allocating additional resources for this purpose.

Minors should have access to a personal representative to adequately represent their interests, especially when admitted to mental health facilities and throughout the course of such admission. In most instances, their personal representative would be a family member. However, where there is potential or real conflict of interest, there should be legal provisions for the appointment of another independent personal representative. In these cases, legislation may make the State responsible for remunerating such a personal representative.

Consent to treatment of minors also needs attention in legislation. Many jurisdictions use age (usually 18 years) as the sole criterion for determining a minor's right to consent or refuse consent. However, a significant number of minors, especially teenagers, have sufficient maturity and understanding to be able to consent or withhold consent. Legislation may contain provisions to encourage taking into consideration minors' opinions in consent issues, depending on their age and maturity.

Legislation may ban the use of irreversible treatment procedures on children, especially psychosurgery and sterilization.

17.2 Women Stark gender inequalities and discrimination are a matter of fact in many societies around the world. Inequities and discriminatory practices can cause and exacerbate mental disorders in women. Women are often discriminated against in terms of access to mental health services for reasons such as lack of money and a perception of their lack of importance in society. Legislation may actively counter such inequalities and discrimination. The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), which defines what constitutes discrimination against women and sets up an agenda for national action to end such discrimination, represents a useful instrument to guide the development of legislation in this area.

Women who are admitted to mental health facilities should have adequate privacy. Legislation can ensure that all mental health facilities have separate sleeping facilities (single-sex wards) for women, and that such living facilities are of adequate quality and comparable to those provided to men. Legislation may also explicitly protect women from sexual abuse and physical exploitation by male patients and male employees of mental hospitals.

The post-partum period is a time of high risk of mental disorders for women. Treatment facilities for post-partum mental disorders should take into account the unique needs of post-partum women and provide adequate facilities for nursing mothers. In particular, if nursing mothers are admitted to a mental health facility they should not be separated from their infants. The mental health facility may have nursery facilities and skilled staff who can provide care to both mother and baby. Legislation can assist in achieving these goals.

Protection of confidentiality is of particular importance in societies where information concerning a woman can be used against her in some way. Legislation may specifically state that information regarding mental health matters in such situations is never released without the explicit consent of the woman concerned. Legislation should also encourage mental health professionals to take into account the pressures faced by women in many societies to consent to release information to family members.

In countries where women are detained in hospitals on social and cultural grounds it is necessary that legislation explicitly state the illegality of such a practice. Legislation should promote equal access to mental health services, including community-based treatment and rehabilitation facilities for women. Women should also have equal rights to men in relation to issues of involuntary admission and treatment. Legislation could insist that a review body undertake separate and specific monitoring of the proportion of women admitted involuntarily to mental health facilities in order to assess potential discrimination.

17.3 Minorities Discrimination in the provision of mental health services to minorities takes many forms. For example:

minorities may be denied access to community-based treatment facilities and be offered treatment in inpatient facilities instead; minorities have been found to have higher rates of involuntary admission;

social and cultural norms of behaviour which may be different for minorities are sometimes interpreted as signs of mental disorders and lead to involuntary admission;

minorities are more likely to receive involuntary treatment when in mental health facilities;

the living environment of mental health facilities does not take into account the unique cultural and social needs of minorities; minorities with mental disorders are more likely to be arrested for minor behavioural problems leading to higher rates of contact with the criminal justice system.

Legislation may specifically provide protection against such discriminatory practices. For example, legislation could stipulate that a review body monitor involuntary admissions and involuntary treatment of minorities, ensure that accreditation criteria for mental health facilities include provision of culturally appropriate living environments, and monitor the provision of community-based treatment and rehabilitation services to minorities.

17.4 Refugees In some countries, refugees and asylum seekers often receive inappropriate treatment that causes or exacerbates mental disorders. However, they are not afforded the same mental health treatment as citizens of that country. This violates Article 12 of the ICESCR, which "recognises the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".

Legislation can stipulate that refugees are entitled to the same mental health treatment as citizens of the host country."

47) According to a newspaper article published in 'Times of India' on 28th December, 2017, placed on record as Annexure No.1 with the petition, under the caption 'Mentally disabled girl kept chained for 3 years', one mentally disabled girl namely Km. Chandni D/o Narayan Das, R/o Subhash Colony, Rudrapur, aged about 14 years, had been kept chained for years by her parents. Since her father is a daily wager, he is unable to provide the treatment.

48) In the same newspaper, it is highlighted that similarly, a boy in Rudraprayag, namely Pankaj Rana, aged about 22 years, has been kept chained. He is suffering from 'quadriparesis' which renders limbs immobile as well as aphasia which affects the comprehension of speech. The mother of Pankaj Rana is a widow and due to lack of money, she cannot take him to the hospital for treatment.

49) The parents of Km. Chandni need sufficient funds for her treatment, providing her clothes, food and shelter. It is equally impossible for the mother of Pankaj Rana to take care of her son being a widow. Compassion must be the hallmark of any society. We, as a society, have to be sensitive towards the mentally disturbed children. The family of mentally disturbed children always remains under stress and strain. Poverty further aggravates the situation. It must be very painful for the parents to chain their own children.

50) The mentally disturbed children/patients have a fundamental right to privacy, dignity, self-respect, self-preservation, access to quality mental health care and sustenance. The Society should make sincere endeavour to assimilate/integrate the persons who are mentally disturbed in the society. All of us must provide due care and protection to mentally disturbed persons, since it is difficult for them to take decisions of their own. The role of the society is to make an endeavour to protect the rights of mentally disturbed children as guardians and custodians. Mentally disturbed persons need constant love, care, passion and compassion. The role of the family is also very important while taking care of mentally disturbed patient. Patients are required to be treated by duly qualified doctors. Patients should never be kept in isolation or solitary confinement. No stigma should be attached to their illness. Mental illness is required to be treated like any other disease.

51) We have gathered information that the approach of the District Magistrate, Udham Singh Nagar and the Superintendent of Police, Udham Singh Nagar is humane. They are honest and upright Officers besides being thorough professionals in the discharge of their duties. The Senior Superintendent of Police, Udham Singh Nagar is also a duly qualified doctor. Since we are dealing with a mentally disturbed girl child who is chained for the last few years, we deem it fit and proper to appoint the District Magistrate, Udham Singh Nagar and Senior Superintendent of Police, Udham

Singh Nagar as persons in loco parentis for the care, protection, treatment and rehabilitation of Ms. Chandni.

52) Accordingly, the present petition is disposed of with the following directions: -

A. The District Magistrate, Udham Singh Nagar and Senior Superintendent of Police, Udham Singh Nagar are directed to remove the chains of Ms. Chandni D/o Narayan Das R/o Subhash Colony, Rudrapur within six hours. These Officers are also directed to shift Ms. Chandni to the Mental Health Hospital, Selaqui within 24 hours.

B. The District Magistrate, Rudraprayag and Superintendent of Police, Rudraprayag are directed to remove the chains of Mr. Pankaj Rana within six hours. They are further directed to shift Mr. Pankaj Rana to the All India Institute of Medical Sciences, Rishikesh within 24 hours.

C. The District Magistrate, Udham Singh Nagar and the District Magistrate, Rudraprayag are directed to pay and release the ex gratia payment of Rs.50,000/- each to the guardians of Ms. Chandni and Mr. Pankaj Rana within 24 hours for the treatment of their wards.

D. The respondent-State is directed to pay a monthly stipend of Rs.5,500/- each to the guardians of Km. Chandni and Mr. Pankaj Rana for their care and protection including treatment.

E. The State Government is also directed to prepare a comprehensive Policy for rehabilitating the mentally disturbed children and patients.

F. All the SSPs/SPs, throughout the State, are directed to ensure that the mentally disturbed patients are not treated by Tantriks, Quacks etc. and also to ensure that the mentally disturbed patients are not chained/ shackled/fettered/ill-treated or kept in solitary confinement even in the private homes and institutions.

G. The State Government is directed to conduct the Epidemiological Survey Data in the State to determine the mentally retarded/disturbed children through National Institute of Mental Help and Neurosciences, Bangalore (Karnataka) within six months from today.

H. The State Government is advised to set up Centre for Human Rights, Ethics, Law and Mental Health with the objectives, as stated in paragraph no.40 of the judgment.

I. The State Government is directed to constitute the State Authority under Section 45 of the Mental Healthcare Act, 2017 within three months from today.

J. The State Government, thereafter, shall constitute the Board to be called 'Mental Health Review Board' as per Section 73 of the Act within eight weeks.

K. The State Government is directed to provide mental healthcare and treatment to all the persons with mental illness at an affordable cost, of good quality, available in sufficient quantity, accessible

geographically and without any discrimination.

L. The State Government is directed to incorporate mental health service into general service at all levels including primary health centers in all health programmes.

M. The State Government is directed to ensure that no person with mental illness including children and illiterate persons are transferred to long distances to access mental health service.

N. The State Government is directed to ensure that every person, with mental illness, as per Section 20, is protected from cruel, inhuman and degrading treatment in any mental establishment.

O. The State Government is directed as per Section 29 to plan, design and implement programmes for the promotion of mental health and prevention of mental illness in the State.

P. The State Government is also directed to take all necessary measures to give due publicity to the Mental Healthcare Act, 2017 through public media, including television, radio, print and online media at regular intervals.

Q. The State Government is also directed to ensure that no person or organization establishes or runs mental health establishment unless registered with the authority constituted under the Act.

R. The persons suffering from mental illness shall be admitted in the Establishment as per Section 86 of the Act.

S. The practice of electro-convulsive therapy without the use of muscle relaxants and anesthesia, except with the express consent of guardian, is prohibited in the State of Uttarakhand.

T. The State Government would ensure that no person with mental illness is subjected to electro-seclusion or solitary confinement.

U. All the Medical Officers of the Prison or Jail are directed to send quarterly reports to the concerned Board certifying therein that there are no prisoners with mental illness in the prison or jail.

V. The person in-charge of the State run custodial institution (including beggars homes, orphanages, women's protection homes and children homes) is directed to ensure that any resident of the institution has, or is likely to have, a mental illness, he shall take such resident of the institution to the nearest mental health establishment run or funded by the appropriate Government for assessment and treatment.

W.Every police officer in the State of Uttarakhand is directed to take under protection any person found wandering at large within the limits of the police station whom the officer has reason to believe has mental illness and is incapable of taking care of himself. Every person taken into protection is ordered to be taken to the nearest public health establishment forthwith.

X. It shall also be the duty of every police officer to report to the Magistrate if any person, suffering from mental illness, is being ill-treated or neglected.

Y. The State Government is directed to frame the Policy, as undertaken, to register the children suffering from mental illness within six months.

Z. The State Government is also advised to open more Mental Care Establishments taking into consideration the large number of persons suffering from mental illness for their proper treatment, protection and care.

AA. The State Government is directed to open District Early Intervention Centers (DEICs) in every district of the State within six months.

BB. The State Government is directed to ensure that henceforth, no mentally disturbed/retarded person is found on the streets. The concerned SSP/SPs are directed to shift them to the nearest mental health institutions/place of safety.

(Sharad Kumar Sharma, J.) (Rajiv Sharma, J.)

Rdang