

India's Mental Healthcare Act, 2017
- Evaluation of the Act, its Context and Initial Implementation



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Appendices

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Original research (peer reviewed)

- Duffy, R.M., Kelly, B.D. (2017). Rights, laws and tensions: A comparative analysis of the Convention on the Rights of Persons with Disabilities and the WHO Resource Book on Mental Health, Human Rights and Legislation. *International Journal of Law and Psychiatry*, 54, 26-35.
- Duffy, R.M., Kelly, B.D. (2017). Concordance of the Indian Mental Healthcare Act 2017 with the World Health Organization's Checklist on Mental Health Legislation. *International Journal of Mental Health Systems*, 11(1), 48.
- Duffy, R.M., Kelly, B.D. (2017). Privacy, confidentiality and carers: India's harmonisation of national guidelines and international mental health law. *Ethics, Medicine and Public Health*, 3(1), 98-106.
- Duffy, R.M., Narayan, C.L., Goyal, N., Kelly, B.D. (2018). New legislation, new frontiers: Indian psychiatrists' perspective of the mental healthcare act 2017 prior to implementation. *Indian Journal of Psychiatry*, 60(3), 351-354.
- Duffy, R.M., Kelly, B.D. (2019). India's Mental Healthcare Act, 2017: content, context, controversy. *International Journal of Law and Psychiatry*, 62, 169-178.
- Duffy, R.M., Gulati, G., Kasar, N., Paralikar, V., Narayan, C.L., Desousa, A., Goyal, N., Kelly, B.D. (2019). Stigma, inclusion and India's Mental Healthcare Act 2017, *Journal of Public Mental Health*, 18(3), 199-205.
- Duffy, R.M., Gulati, G., Paralikar, V., Kasar, N., Goyal, N., Desousa, A., Goyal, N., Kelly, B.D. (2019). A focus group study of Indian psychiatrists' views on electroconvulsive therapy under India's Mental Healthcare Act 2017: 'the ground reality is different'. *Indian Journal of Psychological Medicine*, 41, 507-515.

Editorials (peer reviewed)

- Duffy, R.M., Kelly, B.D. (2019). The right to mental healthcare: India moves forward. *British Journal of Psychiatry*, 214(2), 59-60.

- Duffy, R.M., Kelly, B.D. (2020). Can the World Health Organisation's 'QualityRights' Initiative help reduce coercive practices in psychiatry in Ireland? *Irish Journal of Psychological Medicine*, 1-4.
- Hoare, F., Duffy, R.M. (2021). The World Health Organisations' QualityRights materials for training, guidance and transformation: preventing coercion but marginalising psychiatry. *British Journal of Psychiatry*, 218(5), 240-242

Letters and correspondence

- Duffy, R.M., Kelly, B.D. (2017). Can psychiatry lead the way in legislating for health and wellbeing? *Irish Medical Journal*, 110(6), 591.
- Duffy, R.M., Kelly, B.D. (2019). Authors' reply. *British Journal of Psychiatry*, 215(2), 504.
- Duffy, R.M., Kelly, B.D. (2019). Global mental health. *Lancet*, 394(10193), 118-119.
- Duffy, R.M. (2019). Letter to the Editor. *Irish Journal of Psychological Medicine*, 36, 235-236.
- Duffy, R.M. (2020). Letter to the Editor, The Limitations of the MHC's report on seclusion and restraint, and suggestions for future reports. *Irish Journal of Psychological Medicine*, 1-2.

Chapters

- Duffy, R.M., Sidhu, D.S., Kelly, B.D. (in press). Optimizing Patient Care in Psychiatry with Autonomy and Choice. In: *Optimizing Patient Care in Psychiatry*. Eds A Srivastava, N Shah, A Desousa. Routledge/Taylor and Francis, USA
- Kelly, B.D., Gulati, G., Duffy, R.M. (in press). Optimizing Patient Care in Psychiatry with Sound Mental Health Legislation. In: *Optimizing Patient Care in Psychiatry*. Eds A Srivastava, N Shah, A Desousa. Routledge/Taylor and Francis, USA

Books – two copies of the book submitted with the thesis

- Duffy, R.M., Kelly, B.D. (2020). *India's Mental Healthcare Act, 2017: Building Laws, Protecting Rights*. Cham: Springer.

Appendix 1 Questioning Route

Focus group questions

The below question formed the general frame work of the questioning route, these were above questions were the uncued questions.

Suggested focus group questions

Phase	Question		Timing
Opening	1	Tell us your name and where you practice psychiatry, and what you enjoy most when not practicing psychiatry.	15 mins.
Introduction	2	Tell us about your use of mental health legislation	10 mins.
Transition	3	When did you start to hear about the new Mental Healthcare Act and what were your first impressions of it.	10 mins.
Key	4	What have you been pleased to see in the new Mental Healthcare Act	15 mins.
	5	Do you have any concerns about the new Act	15 mins.
	6	How do you think the transition between the old Act and the new Act is being managed	15 mins.
Ending	7	If you were writing the legislation, what would you have done differently	10 mins.
	8	Is there any major area that we have not talked about today that you feel is very important concerning the new Mental Healthcare Act.	10 mins.

Alternative question which may be included in stratified focus groups

Phase	Question	Timing
Introduction	What is it like to work in the this particular area (setting, region or specialty)	10 mins.
Key	Are there particular challenges in using mental health legislation in your area of work (addiction, child and adolescent, old age, rural, urban, etc.)	15 mins.
Ending	Are there other groups of psychiatrists who you feel face similar problems	10 mins.

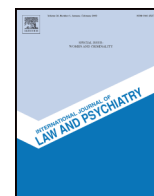
Alternative question which may be included if theoretical saturation is reached on the above question

Transition	Do you often use the Mental Healthcare Act, and what are the main reasons for doing so?	10 mins.
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Key	Do you think the new legislation alters the level of care patients receive and if so how?	15 mins.
Key	Are you familiar with the convention on the rights of persons with disabilities and how do you feel about it influencing the new legislation	15 mins.

Appendix 2 Publications

Original research



Rights, laws and tensions: A comparative analysis of the Convention on the Rights of Persons with Disabilities and the WHO Resource Book on Mental Health, Human Rights and Legislation



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ABSTRACT

Background: Good mental health legislation is essential for ensuring high quality mental health care and protecting human rights. Many countries are attempting to bring mental health legislation in line with the UN – Convention on the Rights of Persons with Disability (UN-CRPD). The UN-CRPD requires policy-makers to rethink the ‘medical model’ of mental illness and existing laws. It also challenges WHO guidelines on drafting mental health law, described in the WHO Resource Book on Mental Health, Human Rights and Legislation (WHO-RB).

Aims: This study examines the relationship between the UN-CRPD and the WHO-RB.

Methods: It compares the documents, highlighting similarities and identifying areas of disagreement. The WHO-RB contains a checklist of human rights standards it recommends are met at national level. This study analyses each component on this checklist and identifies the relevant sections in the UN-CRPD that pertain to each. **Results:** Both the UN-CRPD and WHO-RB address more than just acute exacerbations of illness, providing guidelines on, inter alia, treatment, education, occupation and housing. They are patient-centred and strongly influenced by social rights. The UN-CRPD, however, gives just superficial consideration to the management of acute illness, forensic and risk issues, and does little to identify the role of family and carers.

Conclusion: The UN-CRPD has evolved from disability research and strong advocacy organisations. Careful consideration is needed to enable it to address the specific needs encountered in mental illness. Both the UN-CRPD and WHO-RB highlight common tensions that must be resolved by clinicians, and provide some guidance for stakeholders who commonly need to observe one principle at the expense of another.

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1. Introduction

1.1. International mental health legislation

Mental health law has a complex history, and while many laws were intended to aid individuals with mental illness, some have offered legal justification for discrimination and harmful social stereotypes (Melish, 2014). Mental health legislation emerged from the so-called ‘medical model’ which lead to an emphasis on difference and illness; this in turn promoted separation from mainstream society, stigmatisation and prejudice (Harpur, 2011). Nowhere is this more dramatically seen than in the asylum movement of the nineteenth century (Kelly, 2016a). Sporadic laws evolved firstly for the management of property belonging to people with mental illness; later laws sought to protect society from offenders influenced by mental illness (O’Neill, 2005).

The ‘medical model’ lead to a welfare model which saw individuals as requiring care to be provided for them. This care sought to help people with disabilities to overcome barriers in society but did nothing to address the existence of these barriers. Often, the provision of care further isolated them and erected additional barriers (Harpur, 2011). This model located the perceived deficit as being within the individual rather than identifying and addressing contributing factors within society which limited the person’s ability to realise their potential (Harpur, 2011; Schulze, 2010). Revisions of laws in some countries in the mid twentieth century were well-intentioned but excessively paternalistic, often stigmatising and continued to be informed by the ‘medical model’ (Lieberman & Ogas, 2015). The laws of Ireland, England and Wales typified this model, with a strong focus on involuntary treatment and a paucity of legislation ensuring the protection of people admitted to hospital on a voluntary basis, and minimal consideration of social and economic rights (Kelly, 2011).

Social movements in the 1960s and 1970s began collectively to question the assumptions underpinning this approach (Sabatello,

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2014). In recent decades, legislation and social reform have been harnessed to address the societal barriers individuals with impairments experience, with the aim of minimising the impact of these differences. The social model is replacing the 'medical model'; this model attributes disability to society's response to impairment rather than seeing impairment and disability as synonymous (Harpur, 2011). The World Health Organisation (1980) makes a clear distinction between these two concepts, it defines impairment as: "any loss or abnormality of psychological, physiological, or anatomical structure or function" (p. 27) whereas disability is the restriction or lack of functioning that results from impairment. Psychiatry has been slow to respond and is often hesitant in adopting a social model of disability. Only in recent decades have some countries attempted to reform legislation to make it more patient-centred. India's mental health legislation is particularly relevant to this discussion as it is currently being revised to make it concordant with the United Nations – Convention on the Rights of Persons with Disability (UN-CRPD) (Kelly, 2016b). It is one of many countries moving away from a welfare model to a social model.

Within human rights literature there is a separation between civil rights (addressed in the International Covenant on Civil and Political Rights) and social rights (addressed by the International Covenant on Economic, Social and Cultural Rights) (Schulze, 2010). The UN-CRPD aims to address social rights in addition to civil rights. The difference between civil rights and social rights has historically been somewhat fluid (Tushnet, 1992). Civil rights are seen as absolute, and must be provided irrespective of a society's economic position; these include for example freedom of association, religion and speech. Social rights, by contrast, are dependent on the wealth of the respective society and have economic implications; they include a right to housing, healthcare and education. Civil rights have a well-established position in international law and are widely accepted, whereas social rights have a more tenuous legal footing. This somewhat artificial separation has done much to hamper the cause of human rights (Schulze, 2010). The Vienna Declaration and Programme of Action (United Nations, 1993) sought to address this separation of civil and social rights and the UN-CRPD is the first human right treaty to implement its recommendations. This will have significant implications for future legislation relating to mental health and may well help promote more preventative and social interventions.

1.2. The UN Convention on the Rights of Persons with Disability

One of the driving documents in reforming mental health legislation in recent years is the UN-CRPD (United Nations, 2006). This convention was drafted between 2002 and 2006, in a process that involved both governmental and non-governmental organisations and drew heavily on input from disabled people's organisations (Schulze, 2010). The convention was adopted by the General Assembly of the UN in 2006 and came into force in 2008 (Steinert, Steinert, Flammer, & Jaeger, 2016). Currently there are 160 signatories to the convention. Equatorial Guinea, Botswana, South Sudan, Eritrea, Somalia, and Tajikistan are among the countries yet to sign the treaty. The United States of America, Suriname, Ireland, Netherlands, Libya, Belarus, Uzbekistan, Kyrgyzstan, Bhutan and the Democratic People's Republic of Korea (North Korea) are the main signatories yet to ratify the treaty.

The UN-CRPD does not create any new rights, but rather highlights how existing rights must be implemented in the realm of disability to maximise inclusion and limit stigma and discrimination (Schulze, 2010). The UN-CRPD is composed of a preamble followed by 50 articles, each derived from the Universal Declaration of Human Rights (United Nations, 1948) and core human rights treaties. The first four articles lay out the general principles of the document. This includes definitions, the purpose and general principles. Articles five to 30 provide legislation for the prevention of discrimination on the basis of disability and protect both civil and social rights. This includes, for example, the right to education (Article 24), health (Article 25), privacy (Article 22), mobility (Article 20), independence (Article 19) and freedom from torture

(Article 15) for individuals with disabilities. Women (Article 6) and children (Article 7) are identified as groups at risk of discrimination on multiple levels and their rights are specifically affirmed. Articles 35 to 50 set out the practicalities of implementing this at an international level.

Article 1 of the UN-CRPD states that persons with disabilities include those with long term mental or intellectual impairments (United Nations, 2006). The inclusion of mental health rights with disability rights is key to removing stigma and reducing discrimination of individuals with mental healthcare needs (Morrissey, 2012). Article 1 is a clear expression of the paradigm shift from the medical or welfare model to the social model. This is done by reference to the barriers that limit full and effective participation (Harpur, 2011). Despite this the UN-CRPD gives no definition of what is included in the concept of long-term mental or intellectual capacity.

The preamble to the UN-CRPD lays out twenty-five formative principles which shape and inform the document. These include the International Bill of Human Rights, the Convention on the Rights of the Child, the World Program of Action Concerning Disabled Persons and the Universal Declaration of Human Rights. These principles shed light on the evolution of the UN-CRPD, which has emerged from disability research rather than from the fields of psychology or psychiatry. They do not mention statements pertaining specifically to mental illness; in particular, the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (United Nations, 1991). These principles are only mentioned once by Schulze (2010), in her discussion of the negotiations leading to the development of the UN-CRPD. These principles represented 'soft law' and have been supplanted by the UN-CRPD. However, their omission from both the preamble of the UN-CRPD and the discussion leading to its composition may suggest a desire to distance the UN-CRPD from mental health legislation. No mention is given to other regional conventions on mental health. The reference to mental 'impairment' in Article 1 of the convention, is, possibly, the only specific mention of mental ill-health in the document.

These factors suggest further careful consideration may need to be given to the application of the UN-CRPD in the context of mental health. The practice of psychiatry can present some of the most challenging ethical questions in medicine; issues concerning privacy, autonomy, dignity, independence, health and legal capacity arise on a daily basis and practices like seclusion and involuntary treatments are sources of much ethical debate. Failure to consider the specific implications of the UN-CRPD in the area of mental health may result in the unnecessary limitation of individual's rights. Without clear guidance there is a risk of idiosyncratic resolution of areas of conflict, or the UN-CRPD being ignored as it could be considered impractical for severe or acute episodes of illness. Some potential internal conflicts in the UN-CRPD are laid out in Table 1.

Article 25(b) of the UN-CRPD commits ratifying countries to providing "those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimise and prevent further disabilities.". This protects an individual's right to receive treatment. However, in the case of mental illness this right to treatment will, at times, be in conflict with an individual's right to freedom. Smebye, Kirkevold, and Engedal (2016) highlight how a person with dementia's autonomy can impact on the autonomy of the carer or the health care provider's commitment to non-maleficence. Psychiatry is not the only specialty in medicine where the rights of an individual may be in conflict with the rights of others. In the area of infectious diseases, governments balance the rights of the individual with the public health needs (with varying degrees of success) (Silva & Smith, 2015; Todrys, Howe, & Amon, 2013).

The UN-CRPD views health care as a human right rather than a civil right (Silvers & Francis, 2013). This may account for the more theoretical and principle based approach the UN-CRPD takes. Human rights

Table 1

Some potential internal conflicts within the United Nations' Convention on the Rights of Persons with Disabilities (UN-CRPD) arising in mental health.

Involved articles	Conflicted principles	Example	References
3.a with 3.a	Autonomy conflicted with dignity	Patient with self-neglect requiring hospital admission secondary to a psychotic illness expressing a desire to leave hospital	(Delmar, 2013; Delmar et al., 2011; Smebye et al., 2016)
10 with 14.1	The right to life conflicted with the right to liberty	An individual with suicidal intent secondary to mental illness refusing admission	(Shah, 2012; Shah & Buckley, 2009)
22 with 25.b and 10	The right to privacy conflicting with the right to health and life	Doctors obtaining collateral histories about patients who have refused but pose a risk to themselves or others	(Petrik, Billera, Kaplan, Matarazzo, & Wortzel, 2015)
15.1 with 25.b	The right to freedom from cruel and inhumane treatment and the right to health	A patient with depression which has failed to respond to medication, responded to ECT in the past lacking the capacity to consent	(UK ECT Review Group, 2003)
12.2 with 25 and 26	The right to legal capacity with the rights to health and rehabilitation	New onset psychosis with poor insight refusing treatment.	(Karson, Duffy, Eramo, Nylander, & Offord, 2016)
3a with 25.b	The right to autonomy with the right to health	A patient receiving methadone may not be able to give informed consent due to their addiction to the substance being offered.	(Levy, 2016)

exist because we are humans, whereas civil rights are granted by the laws or constitution of the state. The UN-CRPD is also a document concerning international law rather than national law; we will discuss this in more detail later. A CRPD committee was elected in 2008 and monitors the implementation of the CRPD by nations which have ratified it.

National human rights institutions played a bigger role in the development of the UN-CRPD than in any prior international human rights treaty (Byrnes, 2014), this involvement of national organisations allowed for a greater consideration of the treaty's practical implementation. In the development of the UN-CRPD two leading groups Disability Rights international (DRI) and International Disability Caucus (IDC) were vocal in affirming the retention of legal capacity in all contexts and in affirming deinstitutionalisation (Melish, 2014). DRI are an organisation that promote human rights for people with disability and advocate for their full participation in society, it had been involved in the development of many previous regional and international human rights treaties. The IDC is made up of disabled people's organisations and non-governmental organisations, it was the strongest non-governmental voice in the development of the UN-CRPD (Schulze, 2010). The World Network of Users and Survivors of Psychiatry was part of the steering committee of the IDC (Degener & Begg, 2017). It was adamant that its position on capacity and institutionalisation were non-negotiable (Melish, 2014). In relation to capacity, forced interventions and independent living, it should be noted that there was a very wide range of perspectives; the UN-CRPD required agreement from all parties and as such numerous compromises had to be made. The positions on capacity and community living were not universally seen as positive by all organisations representing persons with disability (MacQuarrie & Laurin-Bowie, 2014). The article on capacity was only agreed in the last few hours of the final meeting and was also seen as a compromise. There was also growing support for forced interventions to be allowed in extreme circumstances; however, time ran out before all delegates could agree and this provision was omitted (Degener & Begg, 2017).

The UN-CRPD is a strong and significant step away from the medical or welfare model towards the social model of disability. It could be argued that it is a nail in the coffin of the 'medical model', Harpur (2011) described it as a novel international norm for government policies that replaces the medical and social models with a human rights paradigm.

1.3. The WHO Resource Book on Mental Health, Human Rights and Legislation (WHO-RB)

The WHO-RB was published in 2005 (WHO, 2005). The aim of this document was to help governments and law makers to draft, adopt and implement good mental health legislation, which respects and fulfils international human rights. The WHO-RB is aimed at those

drafting and amending legislation and those implementing laws. It highlights key topics and principles which the WHO believe should be covered in mental health law. While the focus of the WHO-RB is on national rather than international legislation, it aims to set national law in the context of international human rights. The document highlights that mental health law can promote or undermine human rights, and hence the need to have good mental health legislation. The WHO identifies adequate mental health legislation as a key component to empowerment of persons with mental health problems (WHO, 2013).

This document is divided into three main sections. First, the context of mental health legislation; second, what should be contained in mental health legislation; and finally, a discussion on how such law should be drafted, adopted and implemented. In the first section the document discusses the interface between mental health law and policy. As the WHO document was published a year before the UN-CRPD, it does not discuss its implications. It does, however, discuss the international and regional human rights instruments and the major human rights standards applicable to mental health. In the second chapter, many components are individually discussed; e.g. definitions, voluntary care, oversight and review mechanisms. This section makes up half of the document and is summarised in a checklist in Annex one of the document. This is designed to assist in revision and drafting of mental health law. It identifies twenty-seven key topics and breaks each one down into its important component parts. Each of these twenty-seven topics is further subdivided. This has been previously used in research and legislative analysis (Kelly, 2011; Ofori-Atta, Read, Lund, & MHaPP Research Programme Consortium, 2010).

The importance of this document is highlighted by large variation in mental health laws internationally (Fistein, Holland, Clare, & Gunn, 2009). According to the WHO (2013) 64% of people living in low income countries and 8% in high income countries lack any mental health legislation. In 2013 the WHO laid out an action plan for mental health until 2020 (WHO, 2013). By 2020 the WHO is aiming for 50% of countries to have developed or updated mental health laws in line with existing human rights instruments. Such statistics and goals make the WHO-RB essential reading for many legislators.

1.4. Aim

The UN-CRPD and the WHO-RB lay out the key principles for shaping future mental health legislation. The UN-CRPD anchors, in international law, the paradigm shift to a social model for addressing the needs of persons with mental health problems; the WHO-RB is the most comprehensive international guidelines for drafting mental health legislation. These documents serve diverse functions and are written from different perspectives but both strongly influence national mental health law. Their comparison is consequently important and relevant. This study examines the relationship between the UN-CRPD and the WHO-RB. It

identifies areas of common ground and potential sources of disagreement. This research discusses the potential reasons behind these conflicts and possible solutions to them.

2. Methods

This study compares the WHO-RB and the UN-CRPD. To aid comparison of the two documents we used the checklist from the WHO-RB and analysed each component and its subheadings and compared them to the UN-CRPD. This study analyses each of the twenty-seven components on this checklist and identifies the relevant sections in the UN-CRPD that pertain to each.

3. Results

The UN-CRPD and WHO-RB have many similarities but some key differences. Table 2 analyses the UN-CRPD's perspective on each of the main components in the WHO checklist. It identifies the articles in the UN-CRPD that are most relevant to each WHO checklist component and comments on the concordance of the UN-CRPD with the checklist. Analysis of the 27 components in the checklist revealed that 41% (11/27) are in full agreement and, in the case of one component (4%), the vast majority of the relevant references in the UN-CRPD were concordant. However, in the case of 33% of the components of the WHO checklist (9/27) there was significant or substantial inconsistency with the UN-CRPD. The UN-CRPD must, however, be read as a whole and in the context of its central principles of autonomy, dignity and independence. No component of the WHO checklist was found to be fully in disagreement with the UN-CRPD. For each of the components, there was at

least one section of the UN-CRPD which could support the position held by the WHO-RB. This support was most commonly provided by article 25, the right to health, but this drew heavily on a 'medical model' rather than a social model. Two components from the WHO checklist (7%) were not mentioned at all in the UN Convention and these related to *definitions* and *penalties and offences*.

In the case of three components (11%), the relation between the two documents was more complex. The consistent area of contention was the role and nature of treatment for an individual who has not provided consent. As discussed above, this was a core issue for many of the parties involved in drafting the UN-CRPD, so it comes as no surprise that it remained a source of disagreement. Some of the UN articles support parts of the three relevant WHO checklist components, while others appear significantly inconsistent. These three components relate to: involuntary treatment in the community setting; special treatments; and oversight and review mechanisms. Concerning *involuntary treatment in the community setting*, the UN-CRPD is very much in favour of treatment in a less restrictive setting and strongly affirms treatment in a community setting, while article 12 raises concerns about any form of involuntary treatment.

The level of agreement between the two documents concerning *special treatments* was complex due to the broad array of topics covered under *special treatments* in the WHO checklist, including medical and surgical treatments, electro-convulsive therapy (ECT), psychosurgery and sterilisation. The WHO-RB and the UN-CRPD strongly agree on the requirement for individuals with mental illness to access medical and surgical treatments (although the [Committee on the Rights of Persons with Disabilities \(2014b\)](#), may call this into question if the person is refusing treatment). Both documents strongly oppose the sterilisation of

Table 2

Concordance Between the World Health Organisation's Resource Book on Mental Health, Human Rights and Legislation (WHO-RB) (WHO, 2005) and the United Nations' Convention on the Rights of Persons With Disabilities (UN-CRPD) (UN, 2006).

Headings from the WHO-RB Checklist	Are the WHO-RB and UN-CRPD concordant?	Supporting articles in the UN-CRPD	Conflicting articles in the UN-CRPD
Preamble	Yes	1, 3(b), 4(1)(a), 4(1)(c), 4(2), 4(4), 5(1), 5(2), 19(b), 25(b), 25(c), 26(1)(b).	–
Definition	No	–	–
Access to mental health care	Yes	19(b), 25(b), 25(e), 26(1).	–
Rights of users of mental health services	Yes	1, 3(a), 3(b), 4(1)(c), 4(1)(e), 4(1)(i), 4(3), 15(1), 16, 22(1), 24(1)(a), 27(1)(d), 27(2), 30(1).	–
Rights of families or other carers	Yes, could be stronger	8.1a, 22.1, 23.5	22.1
Competence, capacity and guardianship	No	12.3, 12.4	3.a, 12.2, 12.5, 14.1.b, 15.1, 17, 25.d
Voluntary admission and treatment	Yes	15.1, 14.1, 16, 25.a, 25.d	–
Non-protesting patients	No	12.3, 12.4	3.a, 12.2, 12.5, 14.1.b, 15.1, 17, 25.d
Involuntary admission (when separate from treatment) and involuntary treatment (where admission and treatment are combined)	No	12.4, 14.2, 25.b	3.a, 12.2, 14.1.b, 15.1, 16, 17, 25.d
Involuntary treatment (when separate from involuntary admission)	No	12.4, 14.2, 25.b	3.a, 12.2, 14.1.b, 15.1, 16, 17, 25.d
Proxy consent for treatment	No	12.4	3.a, 12.2, 14.1.b, 15.1, 16, 17, 25.d
Involuntary treatment in the community setting	Complex	12.4, 14.2, 19.b, 25.b, 25.c	3.a, 14.1.b, 15.1, 16, 17, 19.a, 25.d
Emergency situation	No	12.4, 15.1, 25.b	3.a, 12.2, 14.1.b, 15.1, 16, 17, 25.d
Determinations of mental disorder	Yes, could be stronger	25.b, 25.d	–
Special treatments	Complex	15.1, 16, 23.1.b, 23.1.c, 25.a, 25.d	3.a, 12.2, 14.1.b, 15.1, 17, 25.d
Seclusion and restraint	No	12.4	3.a, 12.2, 14.1.b, 15.1, 16, 17, 22.1
Clinical and experimental research	No	4.1.f, 15.1	12.2, 12.4, 15.1
Oversight and review mechanisms	Complex	12.4, 16.3, 33.3	–
Police responsibility	No	13.2, 14.1, 25.b	12.2, 14.1
Mentally ill offenders	No	5.3, 12.4, 13.2	5.1, 12.2, 13.1
Discrimination	Yes	1, 3b, 3e, 4.1, 5.1–4, 6.1, 23.1, 24.1, 24.5, 25, 27.1a, 27.1b, 27.1c, 28.1, 28.2	–
Housing	Yes	3(b), 5(3), 28(1), 28(2)(d), 19(a), 19(b).	–
Employment	Yes	3(b), 8(2)(a)(iii), 26(1), 27.1, 27(2).	–
Social security	Yes	1, 28(1), 28(2)(c), 28(2)(e).	–
Civil issues	Yes	3(c), 4(2), 18(1), 19(a), 21, 22(1), 23(1), 24(1), 24(2), 24(5), 26(1)(b), 29(a), 29(b), 30(1), 30(2), 30(4), 30(5).	–
Protection of vulnerable groups	Yes, but different focus (see discussion)	3(g), 3(h), 6, 7, 8(1)(b), 16(1), 16(2), 16(4), 16(5), 23(3), 24(2)(a), 25, 25(b), 28(2)(b), 30(5)(d).	–
Offences and penalties	Not mentioned	–	–

individuals with mental illness. However, the role of psychosurgery and ECT in an involuntary patient is particularly problematic for the UN-CRPD.

The lack of clarity that arises concerning *oversight and review mechanisms* is due to so much being included under this heading in the WHO checklist. Many different topics are considered in this section by the WHO, while the UN-CRPD considers oversight and review predominantly at an international level. While the UN-CRPD supports a transparent system with checks and balances, it appears broadly opposed to involuntary treatment.

4. Discussion

4.1. Points of agreement

Both documents are highly patient-centred and give much consideration to the protection of individuals from maltreatment, exploitation and discrimination. The UN-CRPD lays out principles central to its interpretation and implementation, these include autonomy, dignity and independence. While the WHO-RB does not directly affirm the same principles it opens with the statement that:

“The fundamental aim of mental health legislation is to protect, promote and improve the lives and mental well-being of citizens” (World Health Organization, 2005 p. 1).

One important similarity between the WHO-RB and the UN-CRPD is the consideration of social rights: both documents are not just concerned with acute exacerbations of illness or the management of property belonging to people attending psychiatric services. The UN-CRPD and the WHO-RB make reference to access to housing, employment, social security, voting, health insurance and privacy, among other things. This is significant as these are often topics not included in legislation (Kelly, 2011; Schulze, 2010).

Both documents make extensive efforts to build on the conventions, international laws and guidelines that were in place at the respective times of composition. Lists are included of influential research and legislation at the beginning of each document and the WHO-RB in particular discusses how these guidelines were considered.

Mental health service-users are encouraged to be active in their own health care and in the development of services for other patients.

Both documents also give consideration to the implementation of mental health law; the UN-CRPD on an international level while chapter three of the WHO-RB considers it on a national level.

4.2. Points of disagreement

Despite the WHO working under the umbrella of the UN, there appear to be mutually exclusive concepts contained in the UN-CRPD and the WHO-RB. Article 2 of the UN-CRPD defines discrimination as “any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field” (UN, 2006). Many of the components included in the WHO checklist would, on a *prima facie* view, appear to undermine or contravene this part of the UN-CRPD.

For example, article 5 of the UN-CRPD prohibits discrimination on the basis of disability and guarantees persons with disability legal protection against discrimination and article 12 states that persons with disability have equal legal capacity in all aspects of life. It has been argued that simply having legislation which only applies to people with disability, in this case mental illness, could be seen to contravene these articles (Symonds, 1998; Wand & Chiarella, 2006). Some countries have sought to address this issue directly; for example, Northern Ireland's new Mental Capacity Act (Northern Ireland) 2016 has moved

away from a focus on “mental health” emphasising instead “capacity”. However, that approach is still not consistent with the UN-CRPD not only because it still discriminates (on the basis of “capacity”), but also because the existence of the convention itself could then be seen as discriminatory. A more pragmatic approach is seen in the spirit of Article 5.4 of the UN-CRPD which states: “Specific measures which are necessary to accelerate or achieve *de facto* equality of persons with disabilities shall not be considered discrimination under the terms of the present Convention”. An extension of this logic would imply that the UN-CRPD or mental health legislation is not discriminatory simply by its existence.

Article 14 of the UN-CRPD states that people with a disability have an equal right to liberty and security. The WHO checklist, however, makes provisions for seclusion, restraint and involuntary treatment and admission; again, appearing to violate the UN-CRPD. Some, including the UN Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, have argued that, in addition to deprivation of liberty, seclusion and restraint amount to cruel and inhumane treatment (United Nations Human Rights Council, 2013). Article 15 of the UN-CRPD specifically protects individuals from cruel, inhuman or degrading treatment or punishment. As discussed later, this is a non-derogable right (a right that cannot be violated under any circumstances) and as such violation of this right is particularly serious and cannot be justified on grounds of risk or secondary to an impairment of mental or legal capacity (UN, 1985).

As demonstrated in Table 2, article 12 is one of the most contentious articles in the UN-CRPD and one of the most difficult articles to harmonise with the WHO-RB. This has been further complicated by the General Comment on Article 12 (Committee on the Rights of Persons with Disabilities, 2014a, 2014b) which seeks to clarify ambiguity in the UN-CRPD and discusses the particular context of mental illness in much more detail than the UN-CRPD itself. Paragraph 13 states: ‘Under article 12 of the Convention, perceived or actual deficits in mental capacity must not be used as justification for denying legal capacity.’ The serious implications of this are further clarified in paragraph 42 which states: ‘States parties must abolish policies and legislative provisions that allow or perpetrate forced treatment, as it is an ongoing violation found in mental health laws across the globe, despite empirical evidence indicating its lack of effectiveness and the views of people using mental health systems who have experienced deep pain and trauma as a result of forced treatment. The Committee recommends that States parties ensure that decisions relating to a person's physical or mental integrity can only be taken with the free and informed consent of the person concerned.’ The General Comment issued by the Committee on the Rights of Persons with Disabilities has been critiqued for failing to involve service users in its development and for lacking clinical expertise (Freeman et al., 2015).

4.3. Omissions

One of the most significant omissions in the UN-CRPD is the lack of clear definitions. Some of these have been highlighted above, including mental illness and intellectual capacity. The WHO-RB identifies the importance of fixed definitions of mental illness and it devotes many pages to the discussion of this. It identifies definitions as a vital component of mental health legislation, as mental health law internationally is being reformed to bring it in line with the UN-CRPD this lack of fixed definitions is particularly worrying. Schulze (2010) highlights that legal interpretation of the scope of protections is exceptionally difficult to designate if the scope remains unclear. Schulze (2010) also highlights how a lack of fixed definition may hinder equal recognition before the law (Article 12) and how it can complicate the collection of data and statistics (Article 31). In fact, no definition for any disability is given in the UN-CRPD. The UN-CRPD has been criticized by other authors for a lack of clear definitions concerning other key terms (Byrne, 2013). During its drafting 50 national definitions were considered but no consensus could be reached. However, Schulze (2010) also points out a number

of benefits to there being a lack of definition, a fixed definition may become out dated and may exclude individuals, who do not conform to a given definition of disability, from the protection of the convention. The list of disabilities mentioned is intentionally left open so as not to leave groups out (Schulze, 2010). Peterson (2014) describes the evolving nature of disability, how a very rigid definition may lead to the exclusion of individuals with certain disabilities and how the UN-CRPD has expanded the definitional constraints of disability. This current situation allows disability to be interpreted and seen from a social and human rights perspective. Peterson (2014) and Kanter (2011) also suggests that the lack of a definition was more intentional than Schulze (2010) suggested.

The UN-CRPD is not unique in using broader definitions. For example, the 2007 revision of the Mental Health Act in England and Wales, replaced four different types of mental disorder with one simpler definition. The WHO-RB identifies that broader definitions are more useful in the protection of rights and suggests that more fixed definitions are useful in the context of care, treatment and service planning. As such the UN-CRPD definition has an important role to play but there are contexts (e.g. service planning and compulsory treatments) where legislators will need to use narrower definitions. These definitions should not negate professional judgement or discretion, and should allow for clinical diagnosis as these situations require.

The UN-CRPD is silent on the relationship between disability (mental illness) and criminal offences, whereas the WHO-RB dedicates a six-page chapter to the rights of mentally ill offenders. The prevalence of mental health issues in custody populations has been highlighted (Andersen, 2004; Rekrut-Lapa & Lapa, 2014) and as such requires the in-depth consideration provided by the WHO document. Lamb, Weinberger, and Gross (2004) discuss the need for special policies to reduce the criminalisation of behavioural disturbances in the mentally ill and emphasis the need for improved communication between mental health services and the police. Articles 12 to 14 of the UN-CRPD, if taken too literally, could actually increase the criminalisation of patients. Freeman et al. (2015) highlighted that the UN-CRPD may be inconsistent with a so-called insanity defence and may inappropriately affirm or assume an individual's fitness to plead in the context of acute severe illness.

The UN-CRPD makes no mention of emergency situations (acute exacerbations of illness, or suicidal crises); by way of contrast, the WHO-RB considers these events in detail, and explicitly addresses the treatment of individuals in crisis. This includes a definition of an emergency, guidelines for admission and treatment in this context, powers to detain and the review of such detention, interactions with the police and research in this context. Allen, Khan, Alzahri, and Stolar (2015) identify the importance of discussing the many ethical challenges faced in treating mental health emergencies. The UN-CRPD's failure to consider the specific challenges of mental illness is a significant omission. The difference in the two documents' approaches can be seen in each document's principles for the protection of minority groups. The UN-CRPD focuses on their rights and need for protection from discrimination in daily life and relating to their disability. The WHO-RB, on the other hand, looks at how these groups need additional protection in emergency situations, and carefully considers the rights of women, children, and minorities during such events as involuntary admission. This may be explained by the theoretical model underpinning each document, the WHO-RB drawing on the 'medical model' while the UN-CRPD is built upon a social model.

In addition, while both documents discuss the role of family in depth, they approach it from very different perspectives. In the UN-CRPD, the primary focus is protection from discrimination in the family environment, privacy and the right to family life. The WHO-RB however, engages in lengthy discussion on the role of the relatives and carers in seeking treatment and the tension between carer involvement and patient privacy. There is also guidance on encouraging family members and carers to become involved in the development of mental health policy and legislation.

The UN-CRPD makes no mention of advance directives or proxy consent, but these are discussed at length in chapter 2 of the WHO-RB. These two topics exemplify how mental illness does not easily conform to the patterns of other disabilities, as the condition itself may impair the individual's decision-making concerning their own health care. The person's ability to exercise their legal capacity may also vary significantly secondary to the disability. In contrast to other disabilities, decision-making capacity in mental illness is more changeable and, as a result, careful consideration of advance directives, proxy decision making, and involuntary treatment are essential. Advance directives are mentioned in the General Comment on Article 12 and while there is provision made for their use, lack of mental capacity is explicitly mentioned as an inappropriate criterion for bringing an advance directive into force (Committee on the Rights of Persons with Disabilities, 2014a, 2014b). Paragraph 7 states: 'Historically, persons with disabilities have been denied their right to legal capacity in many areas in a discriminatory manner under substitute decision-making regimes such as guardianship, conservatorship and mental health laws that permit forced treatment. These practices must be abolished in order to ensure that full legal capacity is restored to persons with disabilities on an equal basis with others.'

Paragraph three replaces the idea of proxy decision making with supported decision making. There is an internal inconsistency in the General Comment in that the advance directive comes into force when a person's capacity becomes impaired and this implies that capacity *can* be impaired. If the person is in this situation retains capacity they will be able to override their own advance directives, thus rendering them redundant (Freeman et al., 2015).

In summary the UN-CRPD and the WHO-RB are guided by similar principles, and are both rights-based and patient-centred. It is their evolution and theoretical basis which gives them their individual perspectives. The UN-CRPD, strongly influenced by the social model and disability and equality research, is excellent at highlighting the many ways that mental health law can limit or violate human rights. The WHO-RB on the other hand seems to have developed from the 'medical model' and practice of psychiatry and as such has many strong practical perspectives and a deep awareness of the risks and ethical problems posed by severe mental illness.

One final perspective which may help understand these documents is their different target audiences. The WHO-RB is targeted at a national and regional level, it aims to guide the drafting, amending, adoption and implementation of mental health legislation. It is solely focused on mental illness. This allows the WHO-RB to target more specific areas in greater detail and to consider the particular implications of mental illness distinct from disability as a whole. The UN-CRPD, by contrast, addresses all disabilities. It was drafted to be international legislation and as such has a far broader target audience. This includes individuals with disabilities, organisations working in the area of disability, policy makers and members of the legal profession. This broader scope limits the UN-CRPD's ability to consider topics in the detail covered in the WHO-RB. This broad scope may account for the omissions concerning emergency situations and criminal offences, failure to consider the implications of the UN-CRPD in these context may have unintended adverse outcomes for people with mental illness who have committed crimes or who require emergency treatments (Freeman et al., 2015). In the drafting of the UN-CRPD these topics were considered but as agreement could not be reached they were omitted from the final draft (Degener & Begg, 2017). This omission could have significant implications for individuals with severe mental health problems. The UN-CRPD's position as a legal document also requires it to be more definitive in its statements.

4.4. International vs national law

In addition to the differences that arise from the model of disability, many of the differences between these two documents can

Table 3
Analysis of the differences between rights, legislation and policy in mental health.

	International legislation (rights)	National legislation (laws)	Policy
Target population to whom it applies	Universal	Country or subsection of a country	National, regional, local
Entity which it applies to	State	All individuals, companies or services	Particular individuals, companies or services
Guidance	General principles	Specific principles	Specific principles, local guidance.
Goals	Aspirational but has been successfully tested in courts	Must be attainable	May be aspirational or attainable
Focus on	Content	Content, context and process equally important	Content, context and process equally important
Scope	Holistic	Deals with emergencies and extreme circumstances	Holistic and emergencies
Practicalities realizing	Not considered	Considered	Central
The role of finance	Not considered	Should be considered but not always	May be considered
Failure to obey guidelines	No penalties for not complying	Penalties for not complying	Variable, e.g. incident reporting
Mutability	Static or very slow to change	Dynamic, should evolve as situations change in a country	Very dynamic can change annually
Speed of action	Slow	Fast	Fast

Note: This table is formulated as a discussion document, as the applicability and justiciability of international law depends on the area involved; this table refers specifically to the area of mental health.

be understood and resolved by a discussion of international law, national law and policy. The boundaries between these three concepts are not always distinct and there is often overlap. Some of the key differences in the area of mental health are laid out in Table 3. While the WHO-RB is concerned with the practicalities of constructing and implementing national law, the UN-CRPD dedicates many of its articles to the international implications of the convention. International law is, in some ways, formulated at such a high level that it appears aspirational but it can inform and influence new legislation or provide a context in which national law can be interpreted. The UN-CRPD has been used in this manner in the UK (Law Commission, 2017). The UK Supreme Court has made this explicit:

“The whole point about human rights is their universal character. The rights set out in the European Convention are to be guaranteed to “everyone” (article 1). They are premised on the inherent dignity of all human beings whatever their frailty or flaws. The same philosophy underpins the United Nations Convention on the Rights of Persons with Disabilities (CRPD), ratified by the United Kingdom in 2009. Although not directly incorporated into our domestic law, the CRPD is recognised by the Strasbourg court as part of the international law context within which the guarantees of the European Convention are to be interpreted. Thus, for example, in *Glor v Switzerland, Application No 13444/04*, 30 April 2009, at para 53, the Court reiterated that the Convention must be interpreted in the light of present-day conditions and continued: ‘It also considers that there is a European and Worldwide consensus on the need to protect people with disabilities from discriminatory treatment’.”¹

The authority of the UN-CRPD has thus been tested and affirmed in national and international courts (Committee on the Rights of Persons with Disabilities, 2013; Committee on the Rights of Persons with Disabilities, 2014a). At times, however, international laws may be mutually exclusive or the interpretation of them may remain unclear (Law Commission, 2017). National legislation, on the other hand, is formalised local law seeking to realise as many of these aspirations as possible in a particular country or state. And policies are the rules and guidelines implemented *in practice* to realise these aspirations in a given context. Some components will be covered on all three levels (Table 3), while for others this may not be necessary.

The application of international law is often complex and protracted, particularly in the area of human rights treaties (Shelton, 2015). The WHO-RB acknowledges that national legislation needs to be written in the context of international standards and rights but it also discusses how the national law needs to take practical issues into consideration.

The UN-CRPD is a document that lays down guiding principles without in-depth consideration for the financial implication of these statements. The WHO guidelines, by contrast, highlight the importance of the financial situation of individual countries, overly ambitious legislation runs the risk of being ignored or having negative financial implications for a country.

The WHO-RB discusses the role of sanctions against individuals who violate mental health laws. The UN-CRPD also considers the violation of rights but on a national level rather than an individual level. This is laid out in the optional protocol to the UN-CRPD (additional articles which complement the UN-CRPD).

4.5. Harmonising the WHO-RB and the UN-CRPD

The UN-CRPD lays out clear rights for individuals with disabilities and the WHO-RB implies that these can be limited at times. In order to view these documents as compatible we must understand the contexts in which rights can be limited. The limitation of rights is discussed in the WHO-RB in section nine of chapter one. It is accepted that on occasions rights will come into conflict. Against this background, the UN published a document relating to the justification for limitation of rights called the Siracusa Principles (UN, 1985). It states that “All limitations on a right recognised by the Covenant shall be provided for by law” (section IA5). On this basis, good mental health legislation is vital.

The UN also states that limitations of rights should be contestable; the burden of justification lies with the state; decisions must be reasonable; and laws in such matters must be clear and accessible to everyone. The principles outline two issues which may arise in psychiatry which justify the limitation of rights. Paragraph 25 gives provision for limiting certain rights in order to deal with a serious threat to the health of individuals, while paragraphs 33 and 34 suggest that rights may be limited for the protection of “public safety” i.e. to protect the safety of a person's life or physical integrity.

The Siracusa principles (United Nations, 1948) also lay out non-derogable rights (paragraphs 58–60) which cannot be limited in any context. These include freedom from torture, cruel, inhuman or degrading treatment or punishment, and from medical or scientific experimentation without free consent. As such, establishing if seclusion, restraint, involuntary medication and involuntary psychiatric admission amount to cruel and inhumane torture is vital. And while establishing their efficacy as treatments is challenging to do directly (as medical experimentation in this population is forbidden), extrapolations can be reasonably drawn from voluntary populations, and research done with routine data.

The UN-CRPD itself acknowledges in some areas that individuals may need assistance in exercising their legal capacity (e.g. section (j) of its preamble refers to “more intensive support”). Indeed, some of the differences between the UN-CRPD and WHO-RB may be in

¹ P (by his litigation friend the Official Solicitor) v Cheshire West and Chester Council & Anor [2014] UKSC 19 (19 March 2014).

part a product of semantics, as evidenced by the recently published Indian Mental Healthcare Act (2016) which explicitly attempts to comply with the UN-CRPD. To do this, the Act replaces involuntary admission with 'supported admission'; gives significant consideration to advance directives; and legislates for nominated representatives to assist the patient in exercising their capacity. Seclusion is explicitly forbidden but restraint is discussed in the Act. [Section 4](#) discusses mental capacity and lays out the criteria needed to deem someone as lacking mental capacity. This could be seen to contravene Article 12 of the UN-CRPD, but the Act clearly states that mental capacity is not considered absent on the grounds of mental illness but rather on the basis of inability to understand, evaluate and communicate the relevant information.

[Dawson \(2015\)](#) identified that the UN-CRPD can be interpreted in a variety of ways, and that certain interpretations allow for substitute decision-making and involuntary treatment. Others have argued that involuntary treatment and the UN-CRPD can be compatible by allowing involuntary treatment on the basis of impaired decision-making rather than on the basis of mental illness ([Szmukler, Daw, & Callard, 2014](#)). The General Comment on Article 12 have made this second solution more problematic, but, while conflicts still exist, the arguments above demonstrate that much can be done to minimise apparent contradictions and reduce the limitations of patient's rights.

4.6. Tension

Paradoxically, the apparent areas of conflict or contradiction highlighted in this paper can actually assist with the practice of psychiatry, in that they highlight key tensions inherent in much clinical practice. The ability to hold divergent principles in tension without over emphasising one at the expense of the other is vital. The UN-CRPD and the WHO-RB bring many of these competing principles into focus and lay out the importance of striving to observe various different principles *even though they may appear mutually exclusive*. Six of the key tensions are discussed briefly below.

4.6.1. Autonomy in tension with dignity

Occasionally a person's freedom may appear to be in conflict with their dignity. In psychiatry, autonomy is sometimes limited in the hope of maintaining dignity ([Delmar, 2013](#); [Delmar, Alenius-Karlsson, & Mikkelsen, 2011](#); [Smebye et al., 2016](#)). For example, when a patient is admitted on an involuntary basis with self-neglect secondary to psychosis. It is important to exhaust all non-restrictive treatment options before considering the need for involuntary treatment. If such treatment is necessary, as much autonomy as possible must be afforded to the individual. [Wexler \(1996\)](#) has highlighted that there is not a dyadic opposition between autonomy and dignity but rather they are connected as complementary and supportive values. A patient refusing treatment may also encourage a therapist to respect their dignity and autonomy. This perspective affirms the principle that all human rights are interdependent and interrelated ([United Nations, 2006](#)) and the interaction between autonomy and dignity must be held in careful balance.

4.6.2. Restrictive in tension with ineffectual treatment

Psychiatrists should generally opt for the least restrictive interventions in line with the UN-CRPD but this can result in individuals being denied interventions for treatable mental illness. On occasion, the seriousness of untreated illness may call for a more restrictive course of action. This is of particular concern given the impact of duration of untreated psychosis on social and psychological outcomes ([Penttilä, Jääskeläinen, Hirvonen, Isohanni, & Miettunen, 2014](#)). It is necessary to consistently evaluate the patient's will and preference so as to minimise the extent and duration of restrictive practices.

4.6.3. Universal in tension with personalised treatment options

Both the UN-CRPD and WHO-RB highlight the importance of rights and clear guidelines on treatment; these must shape practice. The two documents also detail the many areas of personal life that psychiatrist may not consider at the time of acute illness. This must draw attention to the individual needs of the patient. At times these can come into conflict and again a balance must be struck.

4.6.4. Ideal in tension with pragmatic treatment

The contrast between the approach of the UN-CRPD (representing the ideal) and the WHO-RD (representing the pragmatic), demonstrate a common conflict. For example, many patients who would be ideal candidates for receiving treatment in a community setting may have a preference for admission, and while this may not be the preferred location for treatment, the patient's preference, social factors, and management policies, may make this necessary at times. Conversely, strongly evidence-based psychological interventions may not benefit certain individuals due to their current social situation, mental state or willingness to engage. These individuals may respond better to a supportive, albeit less evidence-based approach. While we must strive for the highest level of care possible, this striving should not result in the pursuit of idealised or academic goals at the expense of patient well-being. Delivering evidenced based interventions is not the end in itself it is only a means to an end; our aim must be the patients' health, well-being and full participation in society.

4.6.5. Individual in tension with society

The UN-CRPD is firmly focused on the individual. The WHO-RB, on the other hand, has a broader focus, considering implications for society at large. This is a particularly important debate in the areas of risk, forensic psychiatry and, to a lesser extent, addiction psychiatry. While the individual must be the focus of our interventions, the impact on society cannot be ignored.

4.6.6. Involvement in tension with privacy

The contrasting approach to carers' rights to be involved in care in the two documents is striking, and it highlights the very difficult balance that clinicians must establish. Family involvement is often central to treatment ([Pharoah, Mari, Rathbone, & Wong, 2010](#)); families are often involved in the involuntary admission process in psychiatry ([O'Donoghue et al., 2010](#)); and lack of discussion with relatives is often mentioned as a concern among families. The patient, however, has a right to privacy. This privacy has limits, especially in cases where the patient poses a risk to themselves or others, but establishing the correct balance is one of the most challenging areas in psychiatry. Like many of the topics discussed above a decision to breach confidentiality is not a binary one, with a clinician choosing whether or not to breach confidentiality. Rather, it includes multi-layered decisions about who to inform, when to inform them and what information to relate to them.

5. Conclusion

Thirty-one countries have yet to ratify the UN-CRPD. Article 4 in particular would have significant legislative implications, as countries would be committing to adopt and modify laws, bringing them in line with the UN-CRPD. In addition, these countries would have an obligation to take the principles into account in all policies and programmes. These onerous implications may account for hesitancy in ratifying the Convention. Ratifying the UN-CRPD would, arguably, provide individuals affected with mental health difficulties legal protection in line with the most up to date international standards.

Both the UN-CRPD and WHO-RB address a broad range of life experiences of the mentally ill other than psychiatric treatment, including housing, education, occupation and community based interventions; this represents a firm shift away from the 'medical model' to a social model of disability. While these important topics may be addressed in

various ways in various policies, they could be strengthened and protected by an enhanced legal framework. Such law would bridge the gap between international rights standards and national policies. Legislation is needed which focuses on supporting the individual in a holistic sense and protecting them from discrimination, rather than focusing on managing crisis presentations. Laws should provide sufficient protection from discrimination in areas like housing, education and employment. It is not necessary that these laws are contained in explicit mental health legislation but it is important that they are in place somewhere in the statute book and that they work for the mentally ill on an equal basis with others. In theory, ratification of the UN-CRPD should grant individuals with disability the required legal protections but implementation at national levels has been questionable. For example, the [United Nations Committee on the Rights of Persons with Disability \(2016\)](#) identified numerous failings in the UK's implementation of the convention. This report also highlighted how jurisdictions will often dispute their non-adherence. In light of this it is essential that relevant national laws and policies are enacted to further secure the rights of individuals with disabilities. The UN-CRPD also puts a legal onus on governments to make these changes to law and policy.

Both the UN-CRPD and WHO-RB highlight the need for greater evidence for the effectiveness of treatments that are delivered on an involuntary basis. Systematic evidence is lacking for the utility of involuntary admission, seclusion, restraint and treatment against one's will. Acquiring such data presents many ethical and methodological challenges, however, as the rights of patients are being compromised, the pursuit of such evidence is necessary if such practices are to continue.

The retention of legal capacity by every individual throughout an episode of mental illness was key tenet in the development of the UN-CRPD and this perspective has been strengthened by the [Committee on the Rights of Persons with Disabilities \(2014a, 2014b\)](#). A practical implementation of this may need to be developed which addresses the concerns raised by [Freeman et al. \(2015\)](#). As there was a variety of opinions on this topic during the development of the UN-CRPD it may need to be revisited to specifically address the need of individuals with mental health problems.

The UN-CRPD and WHO-RB should play a central role in future revisions of mental health legislation. The UN-CRPD represents international law and this leaves the UN-CRPD in a much stronger position to influence future policy, practice and legislation. The ethical issues that they highlight should be held in careful consideration by those involved in treating mental illness. In order to facilitate this, more consideration will need to be given to the existing definitions in the UN-CRPD that relate to mental illness. A broader discussion on the conceptualisation of mental illness as a disability, including situations where it is different to other forms of disability, would also aid the UN-CRPD in informing international mental health legislation. The WHO-RB needs to be revised and updated in light of the UN-CRPD.

All curtailment of rights should involve the minimum level of restriction for the shortest possible period of time. Careful consideration needs to be given to the limitation of any rights, and especially those limitations that occur as a matter of policy or are commonplace in treatment centres.

The UN-CRPD is an important document which shifts the model of mental illness from a medical one to a social one. It will undoubtedly shape the future of mental health legislation and is invaluable in affirming social rights in addition to civil rights for individuals with disabilities. The WHO-RB is more adherent to the 'medical model' and this may be the source of many of the apparent conflicts. The comparison of these two documents calls into question the future of this 'medical model'. The WHO-RB can be seen as an attempt at a compromise. It is informed by the social model addressing many of the societal barriers individuals with mental illness face and affirming social rights but it still retains some of the language and some of the approaches of the 'medical model'. With the current services available to support individuals with mental health difficulties some input from the 'medical model'

is needed. The WHO-RB has attempted to provide a framework where this is possible, minimising the limitation of rights while negotiating the apparent ethical conflicts.

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RESEARCH

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Concordance of the Indian Mental Healthcare Act 2017 with the World Health Organization's Checklist on Mental Health Legislation

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Abstract

Background: India is revising its mental health legislation with the Indian Mental Healthcare Act 2017 (IMHA). When implemented, this legislation will apply to over 1.25 billion people. In 2005, the World Health Organization (WHO) published a Resource Book (WHO-RB) on mental health, human rights and legislation, including a checklist of 175 specific items to be addressed in mental health legislation or policy in individual countries. Even following the publication of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) (2006), the WHO-RB remains the most comprehensive checklist for mental health legislation available, rooted in UN and WHO documents and providing the most systematic, detailed framework for human rights analysis of mental health legislation. We sought to determine the extent to which the IMHA will bring Indian legislation in line with the WHO-RB.

Methods: The IMHA and other relevant pieces of Indian legislation are compared to each of the items in the WHO-RB. We classify each item in a binary manner, as either concordant or not, and provide more nuanced detail in the text.

Results: The IMHA addresses 96/175 (55.4%) of the WHO-RB standards examined. When other relevant Indian legislation is taken into account, 118/175 (68.0%) of the standards are addressed in Indian law. Important areas of low concordance include the rights of families and carers, competence and guardianship, non-protesting patients and involuntary community treatment. The important legal constructs of advance directives, supported decision-making and nominated representatives are articulated in the Indian legislation and explored in this paper.

Conclusions: In theory, the IMHA is a highly progressive piece of legislation, especially when compared to legislation in other jurisdictions subject to similar analysis. Along with the Indian Rights of Persons with Disabilities Act 2016, it will bring Indian law closely in line with the WHO-RB. Vague, opaque language is however, used in certain contentious areas; this may represent arrangement-focused rather than realisation-focused legislation, and lead to inadvertent limitation of certain rights. Finally, the WHO-RB checklist is an extremely useful tool for this kind of analysis; we recommend it is updated to reflect the CRPD and other relevant developments.

Keywords: Human rights, Jurisprudence, Psychiatry, Mental disorders, Legislation, Coercion

Background

Mental health in India

Standing at over 1.25 billion, the population of India is the second largest in the world, behind only China. The

United Nations (UN) predicts that by 2022 India's population will surpass that of China and by 2030 India's population will reach 1.5 billion [1].

Mental health is a major concern in India; major depressive disorder is the leading cause of years lived with disability and anxiety is the ninth leading cause [2]. It is estimated that just over one in ten people in India have a mental health issue, one in twenty people suffer

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from depression, and 0.8% have a “*common and severe mental disorder*” [3]. The number of individuals affected by mental illness is enormous; it is estimated that 2.5 million people have schizophrenia, 8.8 million have bipolar affective disorder (BPAD), 36.8 million have anxiety disorders and 13.4 million have alcohol dependence [4]. In 2013, just under 31 million disability-adjusted-life-years (DALY) were due to mental, neurological and substance misuse disorders. Schizophrenia accounted for 1.7 million of those, BPAD for 1.8 million, depression for 11.5 million, alcohol and substance misuse for 3 million, and dementia for 1.8 million [5]. Males in the 30–49 age group have the highest prevalence of mental morbidity; in addition to the impact on these individuals and their families, this has major implications for India’s productivity [3].

Despite the large burden of mental illness only 10% of Indians with mental health problems receive evidence-based treatments [6]. Treatment gaps greater than 70% exist due to insufficient funding of mental, neurological, and substance use disorders [3, 5]. India’s spending on mental health care has consistently been inadequate [7]. In 2011, India spent 4.16% of its gross domestic product on health; 0.06% of this was allocated at a national level for outpatient psychiatric care [8]. India’s number of mental health beds is well below average with only 2.15 beds per 100,000 compared to the global figure of 6.5 [7].

As the burden of mental illness is increasingly recognized, funding is being increased with the hope of ensuring more people receive high quality health care. India is implementing a variety of initiatives to address this large need, close the treatment gap, and reduce the DALYs lost to mental, neurological and substance misuse disorders [9]. These initiatives need to be supported by clear, pragmatic and robust mental health law in line with international human rights legislation.

Mental health legislation is an essential part of delivering high quality mental health care and is especially necessary to protect the rights of individuals receiving such care. At present many countries lack appropriate mental health legislation and consequently many individuals are deprived safe, effective, person-centred services. This has a significant impact on occupational, personal and family life [10]. India has previously led the way in the developing world in attempting to shift the care of individuals with mental illness from asylums to community-based treatments [11], however, without clear legislation and policies and a lack of community based services, results were less than satisfactory [12].

India now leads the way globally in revising mental health legislation in line with international human rights standards. It is hoped that on this occasion that

the desired mental health service will be realised through appropriate legislation and implementation. The WHO is encouraging countries to update their mental health legislation in line with international guidelines and hopes that 50% of countries will achieve this by 2020 [10]. With so many countries needing to revise their laws concerning mental health, India’s proposed revision and its implementation will be highly relevant to many other countries, especially those who have also ratified the UN-Convention on the Rights of Persons with Disabilities (UN-CRPD).

The UN-Convention on the Rights of Persons with Disabilities (UN-CRPD)

In 2006, the UN-CRPD was published and it came into force in 2008. Since then it has been signed by over 160 countries [13]. India ratified the UN-CRPD in 2007 [14].

Under the UN-CRPD, persons with disabilities include those with long-term mental or intellectual impairment [15, 16]. The UN-CRPD attempts to emphasize and address the attitudinal and environmental barriers that individuals with impairments face. This has been perceived as a progressive and irreversible step away from a “medical model” of disability and towards a social model. Rao et al., describe it as a move from a “charity based” to a “rights based” approach to disability [17].

The UN-CRPD appears strongly opposed to involuntary treatments [18] and affirms the legal capacity of individuals at all times. The convention requires that ratifying countries revise their laws to make them concordant with the convention. Consequently, India’s mental health care legislation needed to be reformed and the UN-CRPD duly prompted the drafting of two important pieces of legislation in India: the Mental Healthcare Act 2017 (IMHA) and the Rights of Persons with Disability Act 2016 (RPDA) [17].

The drafting of the UN-CRPD was a long and complex process. In contrast to prior international human rights treaties, human rights organisations were heavily involved from the outset [19]. The World Network of Users and Survivors of Psychiatry played a highly influential role and set forth its views on capacity as non-negotiable, it sought to ban institutional care and forced treatment [20]. Much debate occurred concerning emergency circumstances but in the end time ran out and no provisions were made for these [21]. This may call into question the UN-CRPD’s ability to address all mental health issues, in particular emergency situations. Currently, however, the UN-CRPD provides the legal framework for mental health legislation in all countries that have ratified it.

India's mental health legislation

The first mental health legislation in India was introduced by the British colonial government in 1858, when three Acts relating to mental health were adopted: the Lunacy (Supreme Courts) Act, the Lunacy (District Courts) Act and the Indian Lunatic Asylum Act [22]. These acts focused on asylum-based care but, due to the conditions that many patients found themselves in, pressure mounted on government to reform mental healthcare more generally. In 1912, the Indian Lunacy Act was passed.

Following Indian independence, the Indian Psychiatric Society submitted a revised mental healthcare Bill in 1950 which was finally enacted as the Mental Health Act in 1987. This document introduced many important changes, including modern terminology, the creation of the Central and State mental health authorities, prohibition of non-consensual research, and simplification of discharge procedures [23]. The 1987 legislation, however, faced a lot of criticism from the outset [24]: concerns were raised that it gave more emphasis to legal consideration rather than medical care; its position on the family was criticized; and it failed to make provisions for home-based treatments, among other matters [23]. From the perspective of international law, moreover, the 1987 legislation was not in line with the UN-CRPD when it was published in 2006.

Consequently, India has recently revised its mental health legislation with a new law that has been greatly anticipated [25–28]. On the 8 August 2016 the Rajya Sabha (the upper house of the Indian parliament) unanimously passed The Mental Healthcare Bill, 2016. The stated aim of the Bill was “to provide for mental healthcare and services for persons with mental illness and to protect, promote and fulfil the rights of such persons during delivery of mental healthcare and services and for matters connected therewith or incidental thereto.” This has now been adopted as the IMHA which received the assent of the President on 7 April, 2017.

The Rights of Persons with Disabilities Act 2016 (RPDA)

The IMHA is not the only significant legislative reform in this area in India in recent years; in 2016 the RPDA replaced the Persons with Disability Act 1995. The RPDA received the assent of the Indian President on 27 December 2016 and like the IMHA it explicitly states that its purpose is to give effect to the UN-CRPD.

The RPDA complements the proposed IMHA and legally underpins many of the social and economic rights of individuals with mental illness. In particular, it emphasises respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons; non-discrimination; full and effective participation and inclusion in society; respect for difference and acceptance of persons with disabilities

as part of human diversity and humanity; equality of opportunity; accessibility; equality between men and women; respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities. More specific provisions of relevance to mental illness are discussed further in the relevant sections of this paper.

Two main concerns have been raised about the RPDA. First, it appears to lack synchronicity with the IMHA in certain important respects (e.g. it is not clear how guardianship and nominated representatives will be related). Second, it is questionable whether the general nature of the RPDA enables it to address the particular challenges presented by mental illness [18]. This concern is underlined by the fact that the IMHA does not directly address many of the areas of discrimination or social rights highlighted in the UN-CRPD or the WHO *Resource Book on Mental Health, Human Rights and Legislation* (WHO-RB) (below). These matters are of considerable relevance to the analysis presented in this paper, which considers the new Indian legislation in the context of the standards set out in the WHO-RB, and they are discussed in the relevant sections of the paper.

The WHO Resource Book on Mental Health, Human Rights and Legislation (WHO-RB)

Published in 2005, the WHO-RB seeks to provide guidance to governments on the development of human rights-centred mental health legislation. The largest single section of the document identifies and discusses the key legal issues that should be addressed in national mental health legislation or policy, summarised in Annex One as the “Checklist on mental health legislation”. The WHO checklist contains 175 items, divided into 27 sections, covering all key areas of mental health law.

The checklist, although explicitly informed by the Universal Declaration of Human Rights [29], is not a set of absolute rules and it is not legally binding. There are no sanctions for states which fail to accord with its standards and, unlike the UN International Covenant on Civil and Political Rights, the UN Human Rights Committee does not review WHO member states' reports on compliance. The WHO-RB checklist is, instead, designed to work by influencing states as they redraft and implement national mental health laws. Given the checklist's close links with the Universal Declaration of Human Rights, the authors make the assumption that its standards will be accepted by the international community and deemed worth reflecting in national mental health law [30].

It is arguable, however, that some of the issues that the WHO suggests should be covered by mental health legislation should be covered by mental health, public health or social policy instead. Indeed, the WHO

explicitly states that some countries may address some or all of these issues in general legislation (e.g. equality legislation), other forms of (not legally-binding) regulation, or mental health policy, rather than in specific mental health legislation [30]. The history of psychiatry, however, supports the particular importance of dedicated mental health legislation, rather than non-binding regulation or general law, for protecting the rights of the mentally-ill. The WHO also acknowledges the centrality of law in this process by presenting its final checklist in the WHO-RB as a “Checklist on mental health *legislation*” (our italics). This is why the WHO-RB checklist forms the focus of this analysis: it is the most detailed and comprehensive human rights-based framework developed to date for the analysis of national mental health legislation.

The WHO-RB has two serious limitations and is not the unquestionable gold standard for mental health legislation. Most significantly, it was drafted before the UN-CRPD was completed and consequently is at odds with it in some areas [31]. It discusses involuntary treatment, loss of capacity and emergency treatments these directly conflict with the UN-CRPD. The WHO-RB also does not have the legal standing that the UN-CRPD has.

Ofori-Atta et al. have previously used the WHO Checklist to inform their evaluation of mental health legislation in Ghana [32]. A more quantitative, formal approach was adopted by Kelly who compared 166 checklist items with English, Welsh and Irish mental health legislation [30, 33]. Kelly found that the Mental Health Act 2007 in England and Wales met 54.2% of the WHO standards while the Irish Mental Health Act 2001 met 42.2%. Both Mental Health Acts were found to inadequately address fundamental principles particularly in relation to the rights of voluntary patients, vulnerable patient groups, emergency treatments and economic and social rights.

In the present paper, we adapt a similar methodological approach to the new Indian legislation, seeking to identify the extent to which the IMHA brings Indian legislation into line with the WHO-RB, a key document in this field which also overlaps to a significant (but incomplete) extent with the standards outlined in the UN-CRPD (above).

Methods

This study adopts a “black letter” approach, similar to that used by Kelly [30, 33]. In such an analysis, the focus is on the *content* of the legislation rather than its *effect*. Therefore, this paper primarily compares the written content of the IMHA to the WHO-RB’s checklist (175 items). Where relevant, other pieces of Indian legislation are also considered; e.g. the RPDA 2016, the Indian Penal Code 1860, the Code of Criminal Procedure 1973, the Medical Termination of Pregnancy Act 1971, and the Narcotic Drugs and Psychotropic Substances Act 1985. In order to

draw useful information from the results, we classify each WHO standard as either being met or not met in Indian legislation. Where there is an element of uncertainty, we continue with this dichotomous classification system but discuss the particular item in more detail in the text.

The WHO-RB’s checklist is divided into 27 sections, each identified by a capital letter. Specific standards contained in each section are further identified by numbers, lower case letters and Roman numerals. For clarity and to assist with navigation, these have been included in parentheses in the text.

Two specific methodological points merit mention here. First, emergency treatments laid out in the IMHA are not considered as “involuntary treatments” in our analysis; they are instead compared to the WHO-RB guidelines on “emergency treatments”. Second, section J of the WHO-RB considers “involuntary treatment (when separate from involuntary admission)”; under the IMHA supported (involuntary) treatment is not directly considered outside of a supported (involuntary) admission. However, there is a possibility that in the context of an advance directive a person could receive involuntary treatment outside the context of a supported admission and so we have retained this section and discussed this further in the paper.

Results

Table 1 lists the WHO standards and identifies which standards are met in the new Indian legislation and which are not. Overall, 55.4% (97/175) of the WHO standards are met directly in the IMHA while 68.0% (119/175) are addressed somewhere in Indian legislation (including both the IMHA and other pieces of legislation). The RPDA is the main piece of legislation outside of the IMHA which addresses specific items of the WHO-RB.

Overall, then, India’s compliance with the WHO-RB standards is generally good. It is more concordant with the WHO-RB than the legislation of Ireland or England and Wales [33]. There is, however, a number of areas of low compliance. Some areas show just significant *semantic* differences between the WHO-RB and the IMHA, which may stem in part from the IMHA’s attempt to align with the UN-CRPD. These differences reflect the somewhat different theoretical underpinnings of the two documents and have at times complicated the comparison. These areas are discussed below, but first it is useful to note areas of good concordance with the WHO-RB that attributable to legislation other than the IMHA.

Areas of good concordance with the WHO-RB outside the IMHA

Areas of good concordance in Indian legislation outside of the IMHA are summarised in Table 2. The RPDA does

Table 1 Concordance of India's Mental Healthcare Act 2017 with the World Health Organization's "Checklist on mental health legislation" (World Health Organization, 2005)

Legislative issue			Is Indian legislation concordant or not?
A	Preamble and objectives	1a Does the legislation have a preamble which emphasises the human rights of people with mental disorders?	Yes
		1b Does the legislation have a preamble which emphasises the importance of accessible mental health services for all?	Yes
		2a Does the legislation specify that the purpose and objectives to be achieved include non-discrimination against people with mental disorders?	No
		2b Does the legislation specify that the purpose and objectives to be achieved include promotion and protection of the rights of people with mental disorders?	Yes
		2c Does the legislation specify that the purpose and objectives to be achieved include improved access to mental health services?	Yes
		2d Does the legislation specify that the purpose and objectives to be achieved include a community-based approach?	Yes
B	Definitions	1 Is there a clear definition of mental disorder/mental illness/mental disability/mental incapacity?	Yes
		2 Is it evident from the legislation why the particular term (above) has been chosen?	No
		3 Is the legislation clear on whether or not mental retardation/intellectual disability, personality disorders and substance abuse are being covered in the legislation?	No
		4 Are all key terms in the legislation clearly defined?	Yes
		5 Are all the key terms used consistently throughout the legislation (i.e. not interchanged with other terms with similar meanings)?	Yes
		6 Are all "interpretable" terms (i.e. terms that may have several possible interpretations or meanings or may be ambiguous in terms of their meaning) in the legislation defined?	Yes
C	Access to mental health care	1 Does the legislation make provision for the financing of mental health services?	No
		2 Does the legislation state that mental health services should be provided on an equal basis with physical health care?	Yes
		3 Does the legislation ensure allocation of resources to underserved populations and specify that these services should be culturally appropriate?	No
		4 Does the legislation promote mental health within primary health care?	Yes
		5 Does the legislation promote access to psychotropic drugs?	Yes
		6 Does the legislation promote a psychosocial, rehabilitative approach?	Yes
		7 Does the legislation promote access to health insurance in the private and public health sector for people with mental disorders?	Yes
		8 Does the legislation promote community care and deinstitutionalisation?	Yes
D	Rights of users of mental health services	1 Does the legislation include the rights to respect, dignity and to be treated in a humane way?	Yes
		2 Is the right to patients' confidentiality regarding information about themselves, their illness and treatment included?	Yes
		2a Are there sanctions and penalties for people who contravene patients' confidentiality?	Yes
		2b Does the legislation lay down exceptional circumstances when confidentiality may be legally breached?	Yes
		2c Does the legislation allow patients and their personal representatives the right to ask for judicial review of, or appeal against, decisions to release information?	No
		3 Does the legislation provide patients free and full access to information about themselves (including access to their clinical records)?	Yes
		3a Are circumstances in which such access can be denied outlined?	Yes
		3b Does the legislation allow patients and their personal representatives the right to ask for judicial review of, or appeal against, decisions to withhold information?	Yes

Table 1 continued

Legislative issue			Is Indian legislation concordant or not?
	4	Does the law specify the right to be protected from cruel, inhuman and degrading treatment?	Yes
	5	Does the legislation set out the minimal conditions to be maintained in mental health facilities for a safe, therapeutic and hygienic environment?	No
	6	Does the law insist on the privacy of people with mental disorders?	Yes
	6a	Is the law clear on minimal levels of privacy to be respected?	No
	7	Does the legislation outlaw forced or inadequately remunerated labour within mental health institutions?	Yes
	8	Does the law make provision for educational activities; vocational training; leisure and recreational activities; and religious or cultural needs of people with mental disorders?	Yes
	9	Are the health authorities compelled by the law to inform patients of their rights?	Yes
	10	Does legislation ensure that users of mental health services are involved in mental health policy, legislation development and service planning?	Yes
	1	Does the law entitle families or other primary carers to information about the person with a mental disorder (unless the patient refuses the divulging of such information)?	No
	2	Are family members or other primary carers encouraged to become involved in the formulation and implementation of the patient's individualised treatment plan?	No
E	Rights of families or other carers		
	3	Do families or other primary carers have the right to appeal involuntary admission and treatment decisions?	No
	4	Do families or other primary carers have the right to apply for the discharge of mentally ill offenders?	No
	5	Does legislation ensure that family members or other carers are involved in the development of mental health policy, legislation and service planning?	Yes
	1	Does legislation make provision for the management of the affairs of people with mental disorders if they are unable to do so?	Yes
F	Competence, capacity and guardianship		
	2	Does the law define "competence" and "capacity"?	Yes
	3	Does the law lay down a procedure and criteria for determining a person's incapacity/incompetence with respect to issues such as treatment decisions, selection of a substitute decision-maker, making financial decisions?	Yes
	4	Are procedures laid down for appeals against decisions of incapacity/incompetence, and for periodic reviews of decisions?	No
	5	Does the law lay down procedures for the appointment, duration, duties and responsibilities of a guardian to act on behalf of a patient?	No
	6	Does the law determine a process for establishing in which areas a guardian may take decisions on behalf of a patient?	No
	7	Does the law make provision for a systematic review of the need for a guardian?	No
	8	Does the law make provision for a patient to appeal against the appointment of a guardian?	Yes
G	Voluntary admission and treatment		
	1	Does the law promote voluntary admission and treatment as a preferred alternative to involuntary admission and treatment?	Yes
	2	Does the law state that all voluntary patients can only be treated after obtaining informed consent?	Yes
	3	Does the law state that people admitted as voluntary mental health users should be cared for in a way that is equitable with patients with physical health problems?	Yes
	4	Does the law state that voluntary admission and treatment also implies the right to voluntary discharge/refusal of treatment?	Yes
	5	Does the law state that voluntary patients should be informed at the time of admission that they may only be denied the right to leave if they meet the conditions for involuntary care?	No

Table 1 continued

Legislative issue				Is Indian legislation concordant or not?
H	Non-protesting patients	1	Does the law make provision for patients who are incapable of making informed decisions about admission or treatment, but who do not refuse admission or treatment?	No
		2	Are the conditions under which a non-protesting patient may be admitted and treated specified?	No
		3	Does the law state that if users admitted or treated under this provision object to their admission or treatment they must be discharged or treatment stopped unless the criteria for involuntary admission are met?	No
I	Involuntary admission (when separate from treatment) and involuntary treatment (where admission and treatment are combined)	1a	Does the law state that involuntary admission may only be allowed if there is evidence of mental disorder of specified severity?	Yes
		1b	Does the law state that involuntary admission may only be allowed if there is serious likelihood of harm to self or others and/or substantial likelihood of serious deterioration in the patient's condition if treatment is not given?	Yes
		1c	Does the law state that involuntary admission may only be allowed if admission is for a therapeutic purpose?	No
		2	Does the law state that two accredited mental health care practitioners must certify that the criteria for involuntary admission have been met?	Yes
		3	Does the law insist on accreditation of a facility before it can admit involuntary patients?	Yes
		4	Is the principle of the least restrictive environment applied to involuntary admissions?	Yes
		5	Does the law make provision for an independent authority (e.g. review body or tribunal) to authorise all involuntary admissions?	Yes
		6	Are speedy time frames laid down within which the independent authority must make a decision?	Yes
		7	Does the law insist that patients, families and legal representatives be informed of the reasons for admission and of their rights of appeal?	No
		8	Does the law provide for a right to appeal an involuntary admission?	Yes
J	Involuntary treatment (when separate from involuntary admission)	9	Does the law include a provision for time-bound periodic reviews of involuntary (and long-term "voluntary") admission by an independent authority?	No
		10	Does the law specify that patients must be discharged from involuntary admission as soon as they no longer fulfil the criteria for involuntary admission?	Yes
		1a	Does the law set out the criteria that must be met for involuntary treatment, including: Patient suffers from a mental disorder?	Yes
		1b	Does the law set out the criteria that must be met for involuntary treatment, including: Patient lacks the capacity to make informed treatment decisions?	Yes
		1c	Does the law set out the criteria that must be met for involuntary treatment, including: Treatment is necessary to bring about an improvement in the patient's condition, and/or restore the capacity to make treatment decisions, and/or prevent serious deterioration, and/or prevent injury or harm to self or others?	No
		2	Does the law ensure that a treatment plan is proposed by an accredited practitioner with expertise and knowledge to provide the treatment?	Yes
		3	Does the law make provision for a second practitioner to agree on the treatment plan?	No
		4	Has an independent body been set up to authorise involuntary treatment?	Yes
		5	Does the law ensure that treatment is for a limited time period only?	Yes
		6	Does the law provide for a right to appeal involuntary treatment?	Yes
K	Proxy consent for treatment	7	Are there speedy, time-bound, periodic reviews of involuntary treatment in the legislation?	Yes
		1	Does the law provide for a person to consent to treatment on a patient's behalf if that patient has been found incapable of consenting?	Yes
		2	Is the patient given the right to appeal a treatment decision to which a proxy consent has been given?	No
		3	Does the law provide for use of "advance directives" and, if so, is the term clearly defined?	Yes

Table 1 continued

Legislative issue				Is Indian legislation concordant or not?
L	Involuntary treatment in community settings	1	Does the law provide for involuntary treatment in the community as a "less restrictive" alternative to an inpatient mental health facility?	No
		2	Are all the criteria and safeguards required for involuntary inpatient treatment also included for involuntary community-based treatment?	No
M	Emergency situations	1	Are the criteria for emergency admission/treatment limited to situations where there is a high probability of immediate and imminent danger or harm to self and/or others?	Yes
		2	Is there a clear procedure in the law for admission and treatment in emergency situations?	Yes
		3	Does the law allow any qualified and accredited medical or mental health practitioner to admit and treat emergency cases?	Yes
		4	Does the law specify a time limit for emergency admission (usually no longer than 72 h)?	Yes
		5	Does the law specify the need to initiate procedures for involuntary admission and treatment, if needed, as soon as possible after the emergency situation has ended?	No
		6	Are treatments such as ECT, psychosurgery and sterilization, as well as participation in clinical or experimental trials outlawed for people held as emergency cases?	Yes
		7	Do patients, family members and personal representatives have the right to appeal against emergency admission/treatment?	No
N	Determinations of mental disorder	1a	Does the legislation Define the level of skills required to determine mental disorder?	No
		1b	Does the legislation specify the categories of professionals who may assess a person to determine the existence of a mental disorder?	No
		2	Is the accreditation of practitioners codified in law and does this ensure that accreditation is operated by an independent body?	Yes
O	Special treatments	1	Does the law prohibit sterilization as a treatment for mental disorder?	Yes
		1a	Does the law specify that the mere fact of having a mental disorder should not be a reason for sterilization or abortion without informed consent?	No
		2	Does the law require informed consent for major medical and surgical procedures on persons with a mental disorder?	Yes
		2a	Does the law allow medical and surgical procedures without informed consent, if waiting for informed consent would put the patient's life at risk?	Yes
		2b	In cases where inability to consent is likely to be long term, does the law allow authorization for medical and surgical procedures from an independent review body or by proxy consent of a guardian?	Yes
		3	Are psychosurgery and other irreversible treatments outlawed on involuntary patients?	No
		3a	Is there an independent body that makes sure there is indeed informed consent for psychosurgery or other irreversible treatments on involuntary patients?	Yes
		4	Does the law specify the need for informed consent when using ECT?	No
		5	Does the law prohibit the use of unmodified ECT?	Yes
		6	Does the law prohibit the use of ECT in minors?	No
P	Seclusion and restraint	1	Does the law state that seclusion and restraint should only be utilized in exceptional cases to prevent immediate or imminent harm to self or others?	Yes
		2	Does the law state that seclusion and restraint should never be used as a means of punishment or for the convenience of staff?	Yes
		3	Does the law specify a restricted maximum time period for which seclusion and restraints can be used?	No
		4	Does the law ensure that one period of seclusion and restraint is not followed immediately by another?	No
		5	Does the law encourage the development of appropriate structural and human resource requirements that minimize the need to use seclusion and restraints in mental health facilities?	No

Table 1 continued

Legislative issue			Is Indian legislation concordant or not?	
Q	Clinical and experimental research	6	Does the law lay down adequate procedures for the use of seclusion and restraints, including: who should authorise it; that the facility should be accredited; that the reasons and duration of each incident be recorded in a database and made available to a review board; and that family members/ carers and personal representatives be immediately informed when the patient is subject to seclusion and/or restraint?	Yes
		1	Does the law state that informed consent must be obtained for participation in clinical or experimental research from both voluntary and involuntary patients who have the ability to consent?	Yes
		2a	Where a person is unable to give informed consent (and where a decision has been made that research can be conducted): Does the law ensure that proxy consent is obtained from either the legally appointed guardian or family member, or from an independent authority constituted for this purpose?	Yes
		2b	Where a person is unable to give informed consent (and where a decision has been made that research can be conducted): Does the law state that the research cannot be conducted if the same research could be conducted on people capable of consenting, and that the research is necessary to promote the health of the individual and that of the population represented?	Yes
R	Oversight and review mechanisms	1	Does the law set up a judicial or quasi-judicial body to review processes related to involuntary admission or treatment and other restrictions of rights?	Yes
		1a(i)	Does the above body: Assess each involuntary admission/treatment?	No
		1a(ii)	Does the above body entertain appeals against involuntary admission and/or involuntary treatment?	Yes
		1a(iii)	Does the above body review the cases of patients admitted on an involuntary basis (and long-term voluntary patients)?	No
		1a(iv)	Does the above body regularly monitor patients receiving treatment against their will?	Yes
		1a(v)	Does the above body Authorise or prohibit intrusive and irreversible treatments (such as psychosurgery and ECT)?	Yes
		1b	Does the composition of this body include an experienced legal practitioner and an experienced health care practitioner, and a "wise person" reflecting the "community" perspective?	Yes
		1c	Does the law allow for appeal of this body's decisions to a higher court?	Yes
		2	Does the law set up a regulatory and oversight body to protect the rights of people with mental disorders within and outside mental health facilities?	Yes
		2a(i)	Does the above body conduct regular inspections of mental health facilities?	Yes
		2a(ii)	Does the above body provide guidance on minimising intrusive treatments?	No
		2a(iii)	Does the above body maintain statistics; on, for example, the use of intrusive and irreversible treatments, seclusion and restraints?	No
		2a(iv)	Does the above body maintain registers of accredited facilities and professionals?	Yes
		2a(v)	Does the above body report and make recommendations directly to the appropriate government minister?	Yes
		2a(vi)	Does the above body publish findings on a regular a basis?	No
		2b	Does the composition of the body include professionals (in mental health, legal, social work), representatives of users of mental health facilities, members representing families of people with mental disorders, advocates and lay persons?	Yes
		2c	Is this body's authority clearly stated in the legislation?	Yes
		3a	Does the legislation outline procedures for submissions, investigations and resolutions of complaints?	Yes
		3b(i)	Does the law stipulate the time period from the occurrence of the incident within which the complaint should be made?	No
		3b(ii)	Does the law stipulate a maximum time period within which the complaint should be responded to, by whom and how?	Yes

Table 1 continued

Legislative issue			Is Indian legislation concordant or not?
S	Police responsibilities	3b(iii) Does the law stipulate the right of patients to choose and appoint a personal representative and/or legal counsel to represent them in any appeals or complaints procedures?	No
		3b(iv) Does the law stipulate the right of patients to an interpreter during the proceedings, if necessary?	Yes
		3b(v) Does the law stipulate the right of patients and their counsel to access copies of their medical records and any other relevant reports and documents during the complaints or appeals procedures?	Yes
		3b(vi) Does the law stipulate the right of patients and their counsel to attend and participate in complaints and appeals procedures?	Yes
		1 Does the law place restrictions on the activities of the police to ensure that persons with mental disorders are protected against unlawful arrest and detention, and are directed towards the appropriate health care services?	Yes
		2 Does the legislation allow family members, carers or health professionals to obtain police assistance in situations where a patient is highly aggressive or is showing out-of-control behaviour?	Yes
		3 Does the law allow for persons arrested for criminal acts, and in police custody, to be promptly assessed for mental disorder if there is suspicion of mental disorder?	Yes
		4 Does the law make provision for the police to assist in taking a person to a mental health facility who has been involuntarily admitted to the facility?	No
		5 Does the legislation make provision for the police to find an involuntarily committed person who has absconded and return him/her to the mental health facility?	Yes
T	Mentally ill offenders	1 Does the legislation allow for diverting an alleged offender with a mental disorder to the mental health system in lieu of prosecuting him/her, taking into account the gravity of the offence, the person's psychiatric history, mental health state at the time of the offence, the likelihood of detriment to the person's health and the community's interest in prosecution?	Yes
		2 Does the law make adequate provision for people who are not fit to stand trial to be assessed, and for charges to be dropped or stayed while they undergo treatment?	Yes
		2a Are people undergoing such treatment given the same rights in the law as other involuntarily admitted persons, including the right to judicial review by an independent body?	Yes
		3 Does the law allow for people who are found by the courts to be "not responsible due to mental disability" to be treated in a mental health facility and to be discharged once their mental disorder sufficiently improves?	Yes
		4 Does the law allow, at the sentencing stage, for persons with mental disorders to be given probation or hospital orders, rather than being sentenced to prison?	Yes
		5 Does the law allow for the transfer of a convicted prisoner to a mental health facility if he/she becomes mentally ill while serving a sentence?	Yes
		5a Does the law prohibit keeping a prisoner in the mental health facility for longer than the sentence, unless involuntary admission procedures are followed?	No
		6 Does the legislation provide for secure mental health facilities for mentally ill offenders?	Yes
U	Discrimination	1 Does the law include provisions aimed at stopping discrimination against people with mental disorders?	Yes
V	Housing	1 Does the law ensure non-discrimination of people with mental disorders in the allocation of housing?	Yes
		2 Does the law make provision for housing of people with mental disorders in state housing schemes or through subsidized housing?	Yes
		3 Does the legislation make provision for housing in halfway homes and long-stay, supported homes for people with mental disorders?	Yes

Table 1 continued

Legislative issue				Is Indian legislation concordant or not?
W	Employment	1	Does the law make provision for the protection of persons with mental disorders from discrimination and exploitation in the work place?	Yes
		2	Does the law provide for “reasonable accommodation” for employees with mental disorders, for example by providing for a degree of flexibility in working hours to enable those employees to seek mental health treatment?	Yes
		3	Does the law provide for equal employment opportunities for people with mental disorders?	No
		4	Does the law make provision for the establishment of vocational rehabilitation programmes and other programmes that provide jobs and employment in the community for people with mental disorders?	Yes
X	Social security	1	Does legislation provide for disability grants and pensions for people with mental disabilities?	No
		2	Does the law provide for disability grants and pensions for people with mental disorders at similar rates as those for people with physical disabilities?	Yes
Y	Civil issues	1	Does the law uphold the rights of people with mental disorders to the full range of civil, political, economic, social and cultural rights to which all people are entitled?	Yes
Z	Protection of vulnerable groups			
	Protection of minors	1	Does the law limit the involuntary placement of minors in mental health facilities to instances where all feasible community alternatives have been tried?	Yes
		2a	If minors are placed in mental health facilities, does the legislation stipulate that they should have a separate living area from adults?	Yes
		2b	If minors are placed in mental health facilities, does the legislation stipulate that the environment is age appropriate and takes into consideration the developmental needs of minors?	Yes
		3	Does the law ensure that all minors have an adult to represent them in all matters affecting them, including consenting to treatment?	Yes
		4	Does the law stipulate the need to take the opinions of minors into consideration on all issues affecting them (including consent to treatment), depending on their age and maturity?	No
	Protection of women	5	Does legislation ban all irreversible treatments for children?	No
		1	Does legislation allow women with mental disorders equal rights with men in all matters relating to civil, political, economic, social and cultural rights?	Yes
		2a	Does the law ensure that women in mental health facilities: have adequate privacy?	No
		2b	Does the law ensure that women in mental health facilities: are provided with separate sleeping facilities from men?	No
		3	Does legislation state that women with mental disorders should receive equal mental health treatment and care as men, including access to mental health services and care in the community, and in relation to voluntary and involuntary admission and treatment?	Yes
	Protection of minorities	1	Does legislation specifically state that persons with mental disorders should not be discriminated against on the grounds of race, colour, language, religion, political or other opinions, national, ethnic or social origin, legal or social status?	Yes
		2	Does the legislation provide for a review body to monitor involuntary admission and treatment of minorities and ensure non-discrimination on all matters?	No
		3	Does the law stipulate that refugees and asylum seekers are entitled to the same mental health treatment as other citizens of the host country?	No
AZ	Offences and penalties	1	Does the law have a section dealing with offences and appropriate penalties?	Yes
		2	Does the law provide appropriate sanctions against individuals who violate any of the rights of patients as established in the law?	Yes

This table comprises a slightly edited version of the World Health Organization's “Checklist on mental health legislation” (WHO (2005) WHO resource book on mental health, human rights and legislation. Geneva: WHO)

The table indicates whether legislation in India meets or does not meet specific standards

See text for details and references in relation to individual standards

Table 2 Areas where Indian legislation outside of the Indian Mental Healthcare Act (IMHA) is concordant with the World Health Organization's "Checklist on Mental Health Legislation" (WHO-RB) (World Health Organization, 2005)

Legislative issue	WHO-RB designation	Relevant Indian legislation outside the IMHA
Discrimination	U	Rights of persons with disabilities Act (RPDA) 2016, sections 2(h) & 3
Housing	V	RPDA 2016, sections 12(3), 18(4)(b), 19(3), 65(2)(e), 71(2)(e) & 121(4)(b)
Employment	W	RPDA 2016, sections 19, 20 & 35
Social security	X	RPDA 2016, section 24
Civil issues	Y	RPDA 2016, sections 12(1), 16(i) & 20

much in the area of employment but it may not be sufficient. It protects four per cent of Government jobs for individuals with benchmark disabilities: one per cent is for individuals with visual impairment, one per cent for individuals with hearing impairment and one per cent for individuals with locomotor disability. This leaves one per cent divided between autism, intellectual disability, specific learning disability, mental illness, and multiple disabilities.¹ In light of the prevalence of mental illness (above) [3, 7], this does not provide for equal employment opportunities for individuals with mental illness as required by the WHO-RB (W3).

Areas of low concordance with the WHO-RB across all Indian legislation

Key areas of low concordance with the WHO-RB across all Indian legislation are summarised in Table 3. Families' rights in the day-to-day treatment of their relatives are, essentially, accorded to the individual's nominated representative. As the individual receiving mental healthcare may revoke an appointment of a nominated representative at any time,² the individual's family or carers have no protected right to information (E1), treatment planning (E2) or appeal (E3). There is no provision for anyone to apply for the discharge of mentally ill offenders (E4). Two occasions exist when the family and carers are automatically involved; these are: when planning discharge³ and in the case of a person found wandering in the community.⁴

Involuntary treatment in the community setting (L) is only referred to in the context of emergencies.⁵ The legislation concerning advance directives and capacity does create the possibility for involuntary community treatment (L1) (below) but lacks clear criteria and safeguards (L2).

Areas where comparison is complex

Section I of the WHO-RB deals with involuntary admission and treatment, and comparison with the IMHA is in some ways limited as the IMHA does not legislate for involuntary admission directly. A person may, however, be admitted against their will using "supported admission";⁶ so we assessed this procedure in relation to the WHO guidelines. Supported admissions are only allowed if there is evidence of mental disorder of a specified severity (I1a)⁷; if the individual is posing a risk to them self or others or is unable to care for themselves (I1b)⁸; and if two accredited mental health professionals agree that the individual meets the given criteria (I2).⁹ The admission must be to a registered mental health establishment (I3)¹⁰ and must be the least restrictive care option (I4).¹¹

Under the IMHA, the relevant Mental Health Review Board (MHRB) is informed within seven days of a supported admission (three days in the case of a minor or woman).¹² The admitted person, their nominated representative or an appropriate organisation may appeal this decision (I8).¹³ No automatic review process occurs during the initial admission order. If a section 89 admission continues for its maximum thirty days and ongoing supported admission is required, this can continue under section 90. At this stage, the MHRB is informed and they must review the admission (I5)¹⁴ within twenty-one days (I6),¹⁵ and either permit the admission or order discharge of the individual. These reviews of a supported admission

⁶ IMHA 2017, section 89 & 90.

⁷ IMHA 2017, section 89(1)(a).

⁸ IMHA 2017, section 89(1)(a).

⁹ IMHA 2017, section 89(1)(a).

¹⁰ IMHA 2017, sections 65 & 66.

¹¹ IMHA 2017, sections 89(1)(b) & 90(2)(b).

¹² IMHA 2017, section 89(9).

¹³ IMHA 2017, sections 89(10) & 90(14).

¹⁴ IMHA 2017, section 90(5).

¹⁵ IMHA 2017, section 90(4).

¹ RPDA 2016, section 34(1).

² IMHA 2017, section 14(6).

³ IMHA 2017, section 98(1).

⁴ IMHA 2017, section 100(7).

⁵ IMHA 2017, section 94(1).

Table 3 Areas of low concordance between the Indian Mental Healthcare Act (IMHA) and the World Health Organization's "Checklist on Mental Health Legislation" (WHO-RB) (World Health Organization, 2005)

Legislative issue	WHO-RB designation	Area of omission
The rights of the family	E1-4	Limited rights when they are not the nominated representative
Non-protesting patients	H1-3	Not considered in the IMHA, patients lacking capacity admitted as a supported admission
Involuntary treatment in the community	L1-2	Not directly mentioned outside the context of emergencies, no clear safe guards
Determination of mental illness	N1a-b	No guidelines for necessary level of training or category of professions who can determine mental illness
The rights of minorities	Z2-3	No review body monitors the involuntary admission of minorities and no reference is made to refugees or asylum seekers

continue at a maximum frequency of 180 days (I9).¹⁶ Should an individual no longer fulfil criteria for a supported admission the supported admission must be terminated (I10).¹⁷

As highlighted in our consideration of Section E, families are not always entitled to information concerning the admitted individual. The WHO-RB suggests that patients, family and legal representatives be informed of the reasons for admission and of their rights of appeal (I7). In India, this information is to be imparted through the nominated representative, who, if not already selected by an advance directive, is ideally a relative or career. This may leave family members in a situation where they are not entitled to any information or to appeal an admission. The Indian Act does, however, direct the medical officer to provide the individual and their nominated representative with information concerning the admission, the IMHA and their right to appeal.¹⁸

The Indian Act does not include serious likelihood of deterioration as a criterion for admission, as suggested by the WHO-RB (I1b). There is also no mention of the need for the admission to be for therapeutic purposes (I1c); this is, however, a requirement for independent admissions¹⁹ and is alluded to in the IMHA as supported admission has to be considered to be the least restrictive care option.²⁰ No periodic reviews occur for long-term voluntary adult patients (I9), although mandatory review does occur in the case of minors who are admitted (after thirty days) (I9).²¹

Comparison between the IMHA and the WHO-RB is difficult in the area of involuntary treatment (when

separate from involuntary admission) (J). The IMHA states that all persons have the capacity to make treatment decisions but may require varying levels of support from their nominated representative²²; consequently, treatments are not "involuntary". The IMHA proposes creating a guidance document to aid medical practitioners in assessing an individual's capacity to make treatment decisions,²³ with independent patients defined as having the capacity to make such decisions.²⁴

Under the IMHA, treatment without informed consent can only be given in the context of a supported admission; for this, the patient must be suffering from a mental disorder (J1a)²⁵ and lack the capacity to make informed treatment decisions (J1b).²⁶ The IMHA ensures that a sufficiently qualified practitioner provides a treatment plan (J2) by laying out defining criteria for relevant mental health specialties²⁷ and ensuring that patients receive a treatment plan as soon as possible after admission.²⁸ The duration (J5), review (J4, J7) and appeal (J6) processes for supported treatments are as for a supported admission.

While posing a risk to oneself or others or an inability to care for oneself are considered reasons for supported admission,²⁹ no reference is made to the need to improve a patient's condition, restore decision making capacity or prevent deterioration (J1c). No second opinion is needed for a supported treatment plan (J3), only for admission.

Regarding proxy consent for treatment, the IMHA and the WHO-RB are relatively well aligned. The IMHA

¹⁶ IMHA 2017, section 90(9).

¹⁷ IMHA 2017, section 89(13) & 90(15).

¹⁸ IMHA 2017, section 22.

¹⁹ IMHA 2017, section 86(2)(b).

²⁰ IMHA 2017, section 89(1)(b).

²¹ IMHA 2017, section 87(12).

²² IMHA 2017, section 14(9).

²³ IMHA 2017, section 81.

²⁴ IMHA 2017, section 85.

²⁵ IMHA 2017, sections 89(1)(a) & 90(2)(a).

²⁶ IMHA 2017, sections 86(3), 89(1)(c) & 90(2)(c).

²⁷ IMHA 2017, section 2.

²⁸ IMHA 2017, section 21(1)(c).

²⁹ IMHA 2017, sections 89(1)(a) & 90(2)(a).

provides for a nominated representative to consent on a patient's behalf (K1) if the patient requires nearly one hundred per cent support from them.³⁰ The IMHA also provides for and clearly defines advance directives (K3).³¹ While there is no clear mechanism to appeal against a treatment decision to which proxy consent has been given (K2), the individual's capacity is reviewed every seven to fourteen days³² and the individual has the right to revoke the appointment of a nominated representative at any time.³³

Key omissions in areas of generally good concordance

Many of the twenty-seven sections of the WHO-RB are generally well covered in Indian legislation but, commonly, one or two key standards are not met. These omissions are summarized in Table 4 and discussed in more detail below.

No reference is made in the IMHA to personality disorder (B3) which could be considered a mental illness according to the definition included. The legislation is also ambiguous concerning substance abuse (B3), referring to "mental conditions associated with the abuse of alcohol and drugs".³⁴ This could include intoxication, harmful use of substances, substance dependence, withdrawal, drug induced psychosis and brain damage secondary to substance misuse. The precise extent of this definition requires clarification.

Moreover, it is not, as the WHO-RB requires, clear why particular terms have been chosen (B2), especially as the IMHA aligns itself with the International Classification of Disease,³⁵ but does not use its terminology.

Competency, capacity and guardianship (F) is one of the most important areas where the Indian legislation has low levels of concordance with the WHO-RB, addressing only 50% (4/8) of relevant WHO-RB items. Despite this, the IMHA comprehensively covers a number of important issues. Regarding provision for managing the affairs of people with mental disorders (if they are unable to do so themselves) (F1), the IMHA lays out guidelines for advance directives³⁶ and nominated representatives who would be able to address individual's healthcare decisions should the need arise.³⁷ Other matters could be addressed through guardianship (below). "Capacity" is clearly

defined³⁸ and while "competency" is not (F2), this is nonetheless sufficient to meet the relevant WHO-RB standard (F2). The IMHA also lays down criteria for determining capacity³⁹ and proposes the development of a guidance document for assessing it.⁴⁰

In the IMHA, capacity, advance directives and nominated representatives only pertain to decisions concerning healthcare; no reference is made to financial decisions. Guardianship, which may cover financial and other decisions, is addressed in the RPDA⁴¹ and runs in parallel with the nominated representative in the IMHA. The RPDA describes the provision of a limited guardian who may take legally binding decisions for "a person with disability who has been provided with adequate and appropriate support but is unable to take legally binding decisions".⁴² The procedure for the appointment of a limited guardian is clearly described, but the duties, duration (F5) and areas of responsibilities (F6) of a limited guardian are to be determined by the State governments. In the RPDA, there is no provision for systematic reviews (F7), though this may be prescribed by State governments, and there is the right to appeal the decision (F8).⁴³

The IMHA is very clear on the appointment,⁴⁴ duties and responsibilities⁴⁵ of nominated representatives, though it should be noted that these people do not act on behalf of the individual in the manner described in the WHO-RB (F5), but rather support the decision-making of the individual. The IMHA, however, offers no guidelines about the duration of the nominated representative's activities and this may have important consequences in the future (below).

Emergency situations are addressed in a similar manner in both the IMHA and WHO-RB (M). Emergency treatments are time limited to 72 h (M4)⁴⁶ except in North-East and Hill States where it is extended to 120 h due to local infrastructure.⁴⁷ While research is not explicitly forbidden in emergency situations, it would require ethical approval and would have to comply with all national and international guidelines.⁴⁸

The IMHA does not state that there is a need to initiate procedures for supported admission and treatment, if

³⁰ IMHA 2017, sections 89(7), 90(12) & 94(1).

³¹ IMHA 2017, sections 5–13.

³² IMHA 2017, sections 89(8) & 90(13).

³³ IMHA 2017, section 14(6).

³⁴ IMHA 2017 section 2(1)(s).

³⁵ IMHA 2017, section 3(1).

³⁶ IMHA 2017, sections 5–13.

³⁷ IMHA 2017, sections 14–17.

³⁸ IMHA 2017, section 4.

³⁹ IMHA 2017, section 4.

⁴⁰ IMHA 2017, section 81(1).

⁴¹ RPDA 2016, section 14.

⁴² RPDA 2016, section 14(1).

⁴³ RPDA 2016, section 14(3).

⁴⁴ IMHA 2017, section 14.

⁴⁵ IMHA 2017, section 17.

⁴⁶ IMHA 2017, section 94(4).

⁴⁷ IMHA 2017, section 114(1).

⁴⁸ IMHA 2017, section 99.

Table 4 Key omissions in Indian legislation in areas of otherwise good concordance with the World Health Organization's "Checklist on Mental Health Legislation" (WHO-RB) (World Health Organization, 2005)

Legislative issue	WHO-RB designation	Key omissions
Preamble and objectives	A2a	Failure to emphasise non-discrimination outside of health-care
Definitions	B3	No discussion of personality disorder No clear definitions concerning substance misuse
Access to mental healthcare	C1	No clear plans for funding services
Rights of users of mental health services	D5 D6a	No minimum conditions for mental health establishments Superficial consideration of privacy
Competence, capacity and guardianship	F4-7	Lack of clarity and review process concerning limited guardians No clear duration or systematic review for nominated representatives
Emergency situations	M4 M7	No concept of emergency admission No guidelines for appealing against emergency treatments
Special treatments	O1a O2	No explicit protection from abortion without informed consent Lack of guidance on medical treatments
Seclusion and restraint	P3-4 P5	Potential for prolonged and repeated seclusion. No human resource strategy to minimize use of seclusion and restraint
Oversight and review mechanisms	R1ai R1aiii R1aiv R2aiii-iv	Not all involuntary admissions are automatically reviewed Long-term voluntary patients have no right to external review No review for treatments against an individuals will No guidelines on the collection and publication of statistics
Protection of vulnerable groups	Z2a Z2b	The privacy of women is not given special consideration Women are not guaranteed separate sleeping facilities from men

needed, as soon as possible after the emergency situation has ended (M5). However, transportation of a person to a mental health establishment is part of emergency treatment.⁴⁹ If the nominated representative is present, emergency treatment may only occur with their consent.

No mention is made of abortion in the IMHA. Terminations of pregnancy are permitted in certain contexts⁵⁰ with the woman's consent⁵¹ under the Medical Termination of Pregnancy Act, 1971. Provision is made for women lacking capacity⁵² and this is clarified in the RPDA which states that it may be allowed in cases of severe disability where the opinion of the medical practitioner and the guardian of the woman with disability are considered.⁵³ This does not, however, give explicit protection from abortion without informed consent to individuals with mental illness as required by the WHO-RB (O1a).

The IMHA makes only one reference to medical treatments and none to surgical treatments (except

psychosurgery) (O2). In an emergency, "any medical treatment" can be given if it directly relates to the emergency.⁵⁴ While this may cover an episode of delirium, it cannot apply inside of a mental health establishment or to a supported patient. No direct reference is made to the need for informed consent prior to medical and surgical procedures. However, the government is to ensure that persons with disabilities enjoy legal capacity on an equal basis with others (O2)⁵⁵ and, on this basis, consent would be required from all individuals capable of giving it. Where that capacity to give informed consent is absent either in an emergency situation (O2a) or in the long term (O2b), a limited guardian may make legally binding decisions on behalf of the individual without capacity.⁵⁶

To deal with oversight and review mechanisms required by the WHO-RB (R), three bodies are empowered in the IMHA: the Mental Health Review Boards (MHRB), the State Mental Health Authorities (SMHA) and the Central Mental Health Authority (CMHA).

The MHRBs are responsible for reviewing supported admissions, advance directives, nominated representatives

⁴⁹ IMHA 2017, section 94(1).

⁵⁰ The Medical Termination of Pregnancy Act, 1971, section 3(2).

⁵¹ The Medical Termination of Pregnancy Act, 1971, section 3(4)(b).

⁵² The Medical Termination of Pregnancy Act, 1971, section 3(4)(a).

⁵³ RPDA 2016, section 92(f).

⁵⁴ IMHA 2017, section 94(1).

⁵⁵ RPDA 2016, section 13(2).

⁵⁶ RPDA 2016, section 14.

and adjudicating complaints (R1)⁵⁷ and appeals (R1aii).⁵⁸ MHRBs are informed of all supported admissions but within the first thirty days they only review them at the request of the person admitted or their nominated representative.⁵⁹ Should supported admission be required after the initial 30 days a section 90 admission can be started and following this the MHRB will review the admission.⁶⁰ Should an individual feel aggrieved by the decision of a MHRB, they may appeal to the High Court of the State (R1c).⁶¹ The MHRBs comprise a district judge, a representative of the district, a psychiatrist, a second medical practitioner and two individuals who suffer from mental illness or are care-givers or representatives of organisations advocating for those with mental illness (R1b).⁶²

The IMHA sets up the SMHA and CMHA which will provide regulation and oversight in many areas of mental health (R2). The authority of the CMHA⁶³ and SMHA⁶⁴ are not clearly laid out (R2c) but their roles are covered to some extent in the IMHA. They will conduct inspections of mental health establishments (R2ai),⁶⁵ and maintain a list of registered clinical psychologists, mental health nurses and psychiatric social workers (R2aiv). Guidelines concerning psychiatrists are covered under the Indian Medical Council Act, 1956.⁶⁶ No reference is made to occupational therapists, counsellors, psychotherapists or other specialties working within mental health.

Both the SMHA and CMHA include representatives of the Department of Health and Family Welfare and advise their respective governments (R2av).⁶⁷ The SMHA⁶⁸ and the CMHA⁶⁹ are composed of a wide range of mental health professionals, service users and their representatives, as required by the WHO-RB (R2b).

The MHRBs and the Central and State Authorities will engage in activities which may reduce intrusive treatments but will not produce guidelines or take comprehensive steps to minimize such treatments (R2aii). They plan to develop quality and service provision norms⁷⁰ and prepare a guidance document on assessing

capacity,⁷¹ both of which may limit the use of intrusive treatments. The MHRB in consultation with the SMHA can take measures to protect the rights of persons with mental illness.⁷² The CMHA may also give direction to further regulate the use of seclusion, restraint and psychosurgery. The RPDA also sets up two bodies which may reduce intrusive treatments, these are the State⁷³ and Central⁷⁴ Advisory Boards on Disability. Their roles include advising government, developing policy, monitoring the impact of laws and taking up the cause of persons with disability.

The IMHA lays out clear procedures for the submission, investigation and resolution of complaints (R3a).⁷⁵ In appeals, an individual has a right to choose their nominated representative⁷⁶ but no mention is made of their legal counsel (R3biii), although all persons with mental illness are entitled to receive free legal services in matters relating to the IMHA.⁷⁷

Regarding the protection of vulnerable groups (Z), minors are well protected but the guidelines are not as comprehensive for women and ethnic minorities. While steps are taken to consider the opinion of the minor (Z4), these only relate to admission⁷⁸ or are dependent on the nominated representative.⁷⁹

With regard to women, the IMHA again only addresses gender-based discrimination in relation to healthcare, and not more broadly (Z4).⁸⁰ The RPDA, however, affirms the equality of men and women in its preamble and legislates that government must take measures to ensure that women attain equal rights with others in all areas of life (Z1).⁸¹

Areas of good concordance

The IMHA and the WHO-RB are closely aligned in relation to voluntary admission and treatment (G), guidelines on clinical and experimental research (Q),⁸² police responsibility (S), provisions concerning mentally ill offenders and offences and penalties.

In relation to police responsibility, it does not explicitly state that family members, carers or health professionals

⁵⁷ IMHA 2017, section 82.

⁵⁸ IMHA 2017, sections 77(1), 89(10) & 90(14).

⁵⁹ IMHA 2017, section 89(10).

⁶⁰ IMHA 2017, sections 90(4–7).

⁶¹ IMHA 2017, section 83.

⁶² IMHA 2017, section 74(1).

⁶³ IMHA 2017, section 43.

⁶⁴ IMHA 2017, section 55.

⁶⁵ IMHA 2017, section 67(1).

⁶⁶ IMHA 2017, section 2(1)(y).

⁶⁷ IMHA 2017, section 46(1) & 34(1).

⁶⁸ IMHA 2017, section 46(1).

⁶⁹ IMHA 2017, section 34(1).

⁷⁰ IMHA 2017, sections 43(1)(b) & 55(1)(b).

⁷¹ IMHA 2017, section 81(2).

⁷² IMHA 2017, section 82(3).

⁷³ RPDA 2016, sections 66–71.

⁷⁴ RPDA 2016, section 60–65.

⁷⁵ IMHA 2017, sections 28, 43(1)(c), 55(1)(c), 77(1) & 82(1)(e).

⁷⁶ IMHA 2017, section 14.

⁷⁷ IMHA 2017, section 27.

⁷⁸ IMHA 2017, section 87(3)(b).

⁷⁹ IMHA 2017, section 17(a).

⁸⁰ IMHA 2017, section 18(2), & 21.

⁸¹ RPDA 2016, section 4.

⁸² IMHA 2017, section 99.

can obtain police assistance in situations where a patient is highly aggressive (S2); this is information that the police can consider as a reason to believe that a person has a mental illness.⁸³ No special provision is made to allow police to assist in taking a person to a mental health establishment who requires a supported admission (S4), but the return of a person under a supported admission order who absconded from the mental health establishment is addressed (S5).⁸⁴ While the IMHA is clear on the role and responsibilities of police regarding individuals in the community and prisoners serving a custodial sentence, it is less clear concerning persons arrested for criminal acts (S3). It does give provision for a magistrate to convey such a person to a mental health establishment if required.⁸⁵

The provisions concerning mentally ill offenders (T) are limited in the IMHA but relevant matters are covered in the Code of Criminal Procedure and the Indian Penal Code. The IMHA allows for the transfer of a convicted prisoner to a mental health facility if required (T5)⁸⁶ but the law does not prohibit the keeping of a prisoner in the mental health facility for longer than the sentence (T5a). To provide forensic mental health facilities, the IMHA legislates for mental health establishments (T6) to be created in the medical wing of at least one prison in each State.⁸⁷ Even though no provision is made for secure forensic psychiatry services outside of the prisons, this is still significant progress.

Two sections of the IMHA apply to individuals at the sentencing stage (T3, T4) and these create a provision where an individual may be brought to hospital.⁸⁸ The law states that nothing is an offense if, by reason of unsound mind, the person could not know the nature or illegality of an act (T4).⁸⁹ The appropriate diversion of offenders with mental health disorders *in lieu* of prosecution is briefly alluded to in the IMHA⁹⁰ but it does not give special consideration to the gravity of the offence, the person's psychiatric history, mental health state at the time of the offence, the likelihood of detriment to the person's health, or the community's interest in prosecution, as required by the WHO-RB (T1). The IMHA also allows some provision for people who are not fit to stand trial (T2); this is covered in more depth in the Code of

Criminal Procedure⁹¹ and, if transferred to a mental health establishment, such persons are given the same rights and protections that all patients receive under the IMHA (T2a).⁹²

Areas of well justified non-concordance

Psychosurgery is not forbidden in involuntary patients as suggested by the WHO-RB (O3) but it is only permitted with the consent of the individual and with approval of a MHRB (O3a). Regarding ECT, unmodified procedures are prohibited (O5).⁹³ Informed consent is, however, not required (O4), although consent can be obtained from the nominated representative.⁹⁴ With the permission of a guardian and the MHRB, ECT can be delivered to a minor (O6).⁹⁵ As discussed below, these departures from the WHO-RB may actually serve to enhance the rights of individuals with mental illness.

Discussion

The discussion section of this paper follows the order of the Results section and expands on complex or contentious issues. Areas of good compliance have been mostly omitted from further consideration so as to focus on areas in need of further attention and improvement.

Areas of good concordance with the WHO-RB outside the IMHA

The RPDA is the main piece of legislation that fulfils the WHO-RB outside of the IMHB. The IMHB and the RPDA have different roles. The IMHB applies to only mental illness, while the RPDA includes all individuals with disabilities. As such the IMHA addresses emergency situations not considered in the RPDA. This focus on acute episodes by the IMHB, in contrast to the RPDA can also be seen in relation to proxy decision making. The role of the limited guardian in the RPDA is more holistic and long-term, compared to that of the nominated representative in the IMHA. Both documents are needed to address the varying components of the WHO-RB and while they usually do this in a complementary manner, there are potential areas of conflict between the two acts. This is particularly relevant in the areas of proxy decision making, capacity and supported admission and treatment.

The right to equality and non-discrimination is affirmed in the IMHA,⁹⁶ although this only relates to

⁸³ IMHA 2017, section 100(1).

⁸⁴ IMHA 2017, section 92.

⁸⁵ IMHA 2017, section 102.

⁸⁶ IMHA 2017, section 103(1).

⁸⁷ IMHA 2017, section 103(6).

⁸⁸ IMHA 2017, sections 102 & 105.

⁸⁹ Indian Penal Code, section 84.

⁹⁰ IMHA 2017, sections 102 & 105.

⁹¹ Code of Criminal Procedure, sections 328–335.

⁹² Code of Criminal Procedure, section 335(2).

⁹³ IMHA 2017, section 95(1)(a).

⁹⁴ IMHA 2017, sections 89(7) & 90(12).

⁹⁵ IMHA 2017, section 95(2).

⁹⁶ IMHA 2017, sections 18(2) & 21.

healthcare and not to broader discrimination in other areas of life owing to mental illness. While some of these other areas are addressed in the RPDA, this is still a stark omission from national mental health legislation. This is especially true in light of the role of stigma in preventing people accessing treatment [34] and the prevalence of stigma in mental health [35]. In addition, it is known that stigma in India can have far-reaching consequences outside of access to healthcare [36]. Hence, more specific anti-discrimination provisions are needed in Indian mental health legislation.

A large discrepancy between the IMHA and the WHO-RB concerns mentally ill offenders, but many of these important items are addressed elsewhere in Indian legislation. Forensic psychiatry in India is in development [37] and Kallivayalil et al. [23] astutely recount how the current, unsatisfactory situation has evolved from a long history of governmental apathy. In addition, in order to improve overall coherence, it is clearly important that terminology is consistent across all Indian legislation, as many older acts need updating to remove terms like “lunatic” and affirm a consistent legal stance on capacity which is compatible with the UN-CRPD.

Areas of low concordance with the WHO-RB across all Indian legislation

We adopted a literal but pragmatic approach to our analysis, and so classified the IMHA as non-concordant with 80% of the rights of family and other carers (E). This group’s rights are, at best, indirect in the IMHA, being facilitated through the role of the nominated representative. Outside of this context, the entitlements of family and carers are extremely limited [38]. Asokan [37] has already raised concerns about how a nominated representative may do more harm than good, and questioned their relevance to Indian culture.

The IMHA’s lack of consideration of non-protesting patients is a particular concern. In 2011, 25% of Indian mental health patients had been in hospital for over 6 months [7]. The rising prevalence of dementia [5] highlights the particular urgency of the need for legislation for this group, as individuals with dementia often require significant support to exercise their capacity.

A robust process for reviewing admissions is also vital. The concerns raised above about non-protesting patients may be addressed by the transition from “involuntary” to “supported” admission. In many jurisdictions non-protesting patients are admitted but without the legal protection afforded by involuntary treatment (i.e. automatic review of their admissions and treatment) [33]. Under the IMHA, if an individual’s capacity is impaired to the extent that they need a high level of support in decision-making, they should then be admitted in a supported

manner. This will afford them the necessary protections. We are yet to see how this will be implemented; it is possible that this will be underutilized and many individuals may remain in hospital without their informed consent.

The IMHA does not make specific mention of refugees or asylum seekers. However, at the end of 2015 India had over 200,000 “persons of concern” to the UN High Commissioner for Refugees [39]. These individuals have a high prevalence of mental illness and face many barriers to accessing services; as such, they warrant particular mention and legislative protection [40].

There is also a lack of emphasis on primary health care in the IMHA. This is regrettable because the need for more primary health care has long been recognised in India [41] and services are still insufficient in many areas.

Finally, the WHO-RB suggests that supported admissions should only be allowed if admission is for a therapeutic purpose. Explicitly stating this would prevent supported admissions of individuals who do not benefit from in-patient treatment or are being admitted for primarily social reasons. Again, Indian legislation, like legislation in many other countries, could do significantly more in this regard.

Areas where comparison is complex

Five specific legal constructs in the new Indian legislation adopt perspectives significantly different to those of the WHO-RB and an understanding of these is vital for any comparison of the two documents. These are: advance directives, supported admissions, nominated representatives, limited guardians, and capacity.

The potential effects of advance directives are vast and as the IMHA currently stands it is unclear how these will be utilized. It is not explicitly stated that advance directives only apply to admission. As such, it is possible that, when an individual ceases to have capacity,⁹⁷ their advance directive may state a preference for supported (involuntary) treatment in the community. This opens up the possibility of supported treatment separate from admission, and possibly a version of community treatment orders with relatively poorly delineated parameters and poor review mechanisms. Asokan [37] might well prove prescient in describing the proposed advance directive legislation as a “Pandora’s box”. Some psychiatrists believe the legislation will limit their ability to treat individuals by giving too much freedom [42]. The Committee on the Rights of Persons with Disabilities, however, appears to take the contrasting view that such provisions are overly restrictive for patients [43]. In addition to these concerns, the advance directive process will

⁹⁷ IMHA 2017, sections 5(3) & 81.

likely place additional financial burden on Indian mental healthcare services [42]. Some have suggested that advance directives may result in criminalisation of individuals with mental illness who decline treatment but come into contact with the criminal justice system [44]. The role of advance directives in other jurisdictions has been called into question [45] and requires further careful, constructive thought.

A second construct which hinders direct comparison between the WHO-RB and the IMHA is that of supported admission. The UN-CRPD appears opposed to involuntary treatment [43]. To adhere with this, the individual's capacity is supported by their nominated representative under the IMHA. As a result, the individual with mental illness apparently never entirely loses capacity to make decisions; instead, capacity requires varying degrees of support. While there is an ambiguity in this process, it is an arguably necessary ambiguity owing to the complex and varied situations in which this legislation will apply.

Essentially, what would have been considered an involuntary admission in the past is now to be an admission where an individual requires "a very high level of support, approaching hundred percent support in making decisions".⁹⁸ This is a departure from the WHO-RB which suggests the appointment of a guardian who can make decisions in place of the individual.

This provision of the IMHA is undoubtedly an admirable effort to maximise the rights and autonomy of individuals with mental illness, but the non-dichotomous classification of supported decision-making may reduce an individual's access to the review process. In other words, the IMHA's approach protects the individual's capacity but at a cost. The role of the nominated representative is not subject to sufficient systematic review and lacks discrete time frames; and it is unclear what form that support takes or to what degree it is binding. This opens up the potential for loss of autonomy without the protection of a review process. It seems to be an idealistic abdication of responsibility to move the limitation of rights from trained professionals, acting in accordance with professional standards, to family members or others, with potentially varied priorities and limited experience.

It is unclear to what extent supported admissions will be used. They may be used in the cases of non-protesting patients in addition to patients refusing treatment. While the potential delay (up to 51 days) prior to automatic review is a source of concern, it is also important that timeframes are realistic in the context of services' ability to deliver reviews on time. The WHO highlighted the current limitations in the workforce in Indian mental

healthcare noting that there are just 0.30 psychiatrists, 0.17 nurses, 0.05 psychologists and 0.03 social workers per 100,000 population [8]. Figures for all mental health professional are increasing, though many of these individuals are working in the private sector and exact numbers have not been obtained from many states [7]. Ultimately, issues such as this may well prove the rate-limiting step in implementing the IMHA.

Notwithstanding these concerns, the construct of nominated representative can still be used to fulfil many of the requirements of the WHO-RB. Legally and pragmatically, this tool has strengths and weaknesses. According to the IMHA, *every* adult has the right to appoint a nominated representative.⁹⁹ The nominated representative may be any adult who is competent to perform the "duties assigned to him" and has given written consent to acting in this capacity.¹⁰⁰ If a person has not appointed a nominated representative, one can be appointed for them. The nominated representative advocates for the individual and supports their capacity and decision-making. As already discussed (above), this arrangement avoids treatment being seen as "involuntary". Consistent with this, an individual may "revoke or alter such appointment at any time".¹⁰¹ The role of nominated representative may also, however, limit the role of carers and family members in certain situations [38].

There is a complex and ill-defined relationship between the role of the IMHA-nominated representative and that of the limited guardian under the RPDA. The former concept is more in-line with the UN-CRPD Committee on the Rights of Persons with Disabilities and harmonisation with the UN-CRPD is clearly important for India (and other countries) from a legislative perspective [43]. Despite this, the use of a nominated representative clearly has the potential to result in a greater limitation of rights for certain patients in certain circumstances. This is because under the IMHA decision-making capacity is not a binary concept but rather relates to varying levels of support that are required. Therefore, the concept of a person's capacity being temporally limited for a defined period of time with a clear review process has been replaced with a more nebulous concept where their decision-making is supported by an individual, to an unspecified degree, for a poorly defined duration, with insufficient review.

The absence of a clear duration during which the nominated representative acts may lead to the individual with mental healthcare needs being in coercive situations with very limited review of the "support" they are receiving.

⁹⁹ IMHA 2017, section 14(1).

¹⁰⁰ IMHA 2017, section 14(3).

¹⁰¹ IMHA 2017, section 14(6).

⁹⁸ IMHA 2017, sections 86(3), 89(7) & 90(12).

While the individual in question has the right to revoke the appointed nominated representative at any time,¹⁰² there is no clear guidelines that a person needs to have capacity to alter or revoke their appointment. A MHRB may also revoke an appointment if they feel it is in the interests of the individual.¹⁰³ In addition, while some psychiatrists perceive MHRBs as progressive, they have also been met with some skepticism [44]. Concerns have been raised about recruiting sufficient staff for MHRBs, training of individuals on the MHRBs, and potential disagreements between these boards and treating psychiatrists [46].

Potential tensions stemming from the existence of guardianship together with advance directives and nominated representatives all at the same time have yet to be resolved but could raise serious issues [17].

Finally, the concept of capacity itself is a particularly complex one in the IMHA. One issue that arises in the legislation is whether or not capacity is binary and there is no clear answer to this. In relation to advance directives, capacity is dealt with as either present or absent,¹⁰⁴ but in relation to nominated representatives¹⁰⁵ and admission,¹⁰⁶ there is a supportive model where the level of support is adjusted according to the level of capacity. The IMHA proposes creating guidelines for this area but, in the absence of these, the role and assessment of capacity remain unclear.

Key omissions in areas of generally good concordance

Clear definitions are an essential part of any piece of legislation and as many concepts in psychiatry have a significant subjective component they are particularly important in this field. The UN-CRPD has been hesitant to lay down precise definitions of mental illness and has justified this position as accommodating the evolving understanding of disability and minimising the exclusion of individuals who fall outside of rigid definitions [47]. This position has its drawbacks, however, and may not be tenable for national mental health legislations. For example, it hinders the collection of data which are needed for evidence-based service development.

In addition, as the IMHA sets out to protect the rights of individuals with mental illness, it is important that it can accurately identify such individuals [48]. A clear definition of mental disorder is provided in the Act,¹⁰⁷ but the failure to identify clearly the position of addiction and

personality disorder has important implications. The omission of consideration of personality disorder from the IMHA is particularly problematic.

Under the IMHA, a mental health service has a “duty to provide care, treatment and rehabilitation to a person, having severe stress and who attempted to commit suicide”.¹⁰⁸ High suicide risk was identified in 0.9% individuals in India so this requirement could put an unmanageable burden on mental healthcare services [3]. Certain personality disorders are associated with high rates of suicidality [49] and individuals with personality disorders can make up a significant proportion of the work-load of psychiatric services. In an American population, approximately 15% of adults have at least one personality disorder [50]. Newton-Howes et al. highlight that up to 50% of individuals attending secondary care have a personality disorder [51]. While rates of personality disorder in India are unclear, it is still the case that if government has a duty to provide care and treatment to anyone who attempts suicide,¹⁰⁹ it is inevitable that many individuals with personality disorder will come into contact with the mental healthcare services. Failure to make direct reference to personality disorder may lead to individuals with very severe levels of disability not receiving support that they need [17] or it may lead to inappropriate supported admissions and treatment. Greater clarity is needed.

Adequate diagnosis of mental illness is essential for high quality mental healthcare, and the IMHA is regrettably silent on the categories of professionals or skills required to diagnose mental illness. While this may be a product of the work-force limitations highlighted above, it is still essential that some safeguards are in place, as there is a need for a high level clinical training and judgement for accurate diagnosis [50].

No provision is made for financing mental health services in the IMHA, this omission may limit the realisation of the act. The IMHA enshrines the provision of mental healthcare in legislation, a first for India.¹¹⁰ The WHO have recently identified the potential for legislation to further healthcare aims [52] and psychiatry is well placed to lead the way in this area [53]. The legal onus to provide healthcare, without clear financial resources, however, runs the risk of being perceived as overly idealistic and impractical. This may result in it not being realized or mental health care being provided at the expense of different sectors.

Privacy is a fundamental human right [15, 29]. It is so important that it is discussed under the section of the

¹⁰² IMHA 2017, section 14(6).

¹⁰³ IMHA 2017, section 14(7).

¹⁰⁴ IMHA 2017, section 5(3).

¹⁰⁵ IMHA 2017, section 14(9).

¹⁰⁶ IMHA 2017, section 85(1).

¹⁰⁷ IMHA 2017, section 2(1)(s).

¹⁰⁸ IMHA 2017, section 115(2).

¹⁰⁹ IMHA 2017, section 115.

¹¹⁰ IMHA 2017, section 18(1).

IMHA devoted to protection from cruel, inhumane and degrading treatment.¹¹¹ As the protection from such treatment is a non-derogable human right [54], privacy must be protected at all times. Regrettably, discussion concerning privacy is sparse in the medical literature and in much legislation, including the IMHA and UN-CRPD [38]. The WHO-RB, by contrast, discusses varying forms of privacy in considerable detail, and how they might apply in different contexts. Deeper consideration of privacy in the IMHA would do much to protect the rights of individuals receiving mental healthcare in India and would set an important example for other countries.

The human resource limitations in Indian mental health services [7] increase the need for careful regulation of seclusion and restraint. The IMHA's failure to comply with certain WHO-RB items relating to seclusion and restraint (above and Table 1) may increase the possibility of long durations of seclusion and restraint. With growing movement towards seeing seclusion and restraint as forms of cruel, inhuman or degrading treatment [55], it is essential that these practices, if utilised, are kept within very clearly defined parameters and accompanied by all necessary protections. The large variations in the frequency and duration of seclusion and restraint further underline the need for well-constructed guidelines [56].

A recent study of mental illness in India noted that there are no national level prevalence studies of mental illness in the country [4] although some steps have been taken to address this [3]. The IMHA presented an opportunity to address this data deficit but the legislation does not require even rudimentary data collection. This is regrettable: the limited epidemiological knowledge available impacts significantly on the ability of health service planners and public health officials to address the needs of the mentally ill [5]; national, statutory data collection, underpinned by legislation, would have done much to remedy this deficit.

Areas of well justified non-concordance

The IMHA makes a small but important, progressive deviation from the WHO-RB in the area of psychosurgery. The WHO-RB suggests that psychosurgery should not be permitted for involuntary patients. This could potentially prevent a supported patient receiving a beneficial treatment. The IMHA correctly identifies decision-making capacity rather than status of admission as the key issue here. This is important: Mandarelli et al. demonstrated high levels of decision-making capacity in patients receiving non-consensual psychiatric treatment

[57]. The IMHA affirms that supported patients may retain the capacity to make treatment decisions.

Weaknesses of this study

The WHO-RB recommends that a committee, from a range of disciplines, undertake analysis of legislation using the WHO-RB [58]. This research was, in contrast, conducted by two psychiatrists; our aim, however, was to use the WHO-RB framework to provide an overview of key human rights issues in the legislation and to stimulate further, broader, multi-disciplinary consideration of these matters. In addition, this analysis was conducted by individuals working outside the Indian system with the explicit aim of optimising analytic objectivity and engaging in a purely black letter analysis; i.e. determining to what extent the IMHA *as written* appears to comply with the WHO-RB *in theory*. This is a necessary first step and, now that this is done, there is a need to move forward and complement this work with further collaborative analysis based on first-hand experience of Indian mental health services focussing on the legislation *in practice*. These two kinds of analysis (in theory and in practice) can produce quite different assessments and both serve important purposes.

This type of research does not consider implementation. It focuses instead on the *content* of legal documents. Implementation is a key issue for mental health legislation internationally and has posed particular challenges in low and middle income countries [59]. Twenty-eight years after the enactment of the Mental Health Act 1987, only eleven percent of Indian states had state mental health rules in place and it is suggested that many states were unaware of these rules [7]. Specific measures need to be taken to address common barriers to full implementation which include (but are not limited to) funding, staffing, public health priorities and stigma [60]. Concerns regarding implementation justifiably cast a shadow on the new legislation and warrant future research.

Conclusions

The IMHA is a significant step towards greater recognition and protection of the rights of the mentally ill in India. Such a comprehensive attempt to align national mental health legislation with the UN-CRPD is not only admirable in itself but will surely influence many other countries to do likewise; this is greatly to be welcomed. It is imperative, however, that the Indian legislation does not follow the same path as the Indian asylums described by Wig [11]. These asylums opened with "great hope and expectation" but within a few years become overwhelmed. Lack of services, lack of investment, and demoralisation among service providers resulted in serves-users being neglected despite the original

¹¹¹ IMHA 2017, section 20.

enthusiasm and investment. Failure to invest financially or politically in the realisation of this new Act on the ground could see the IMHA similarly fail the people it seeks to protect. A good piece of legislation that is poorly implemented might well be more damaging to patients than a poor piece of legislation that is implemented well.

There are also specific matters in the IMHA still in need of remedy. References to discrimination on the basis of mental illness relate only to healthcare, and while the RPDA partially addresses this, mental illness still requires further and special consideration in this regard. Specific legislation concerning mental illness would better safeguard the rights of individuals with mental health problems.

The IMHA's attempt to be fully compliant with the UN-CRPD has led, at times, to vague language and opaque terminology on key topics. For example, there is ambiguity concerning the inter-relatedness of capacity, consent and the nominated representative. In addition, in an attempt to minimise restriction of rights, the IMHA may actually result in a greater level of coercion, owing especially to the opacity and insufficient review relating to nominated representatives, which are major concerns and will need careful and comprehensive review once the Act is implemented. These may be concordant with the UN-CRPD on paper but the outcome of the law and its effect on patients' rights are more important than the theoretical principles affirmed by it. Realisation-focused mental health legislation and implementation programmes may do more to protect the health and rights of Indians with psychosocial disabilities than a pure focus on arrangement-focused legislation [61]. In other words, practice trumps theory every time.

Three groups are at particular potential risk: patients being treated in the community under an advanced directive, non-protesting patients, and long-term independent patients. The role of supported treatment in a community setting needs to be directly addressed. This may represent a less restrictive form of treatment in certain cases, but ambiguity in the area of advance directives may circumvent the proposed safeguards and potentially limit the rights of individuals concerned. Similarly, additional consideration should be given to non-protesting patients, although a supported admission framework may indeed prove the most appropriate means of facilitating admission in many such cases. The protection of long term voluntary patients is also an area of concern; the IMHA may reduce the numbers of individuals who remain in hospital as voluntary patients despite having high support needs (above).

Recognizing a patient's capacity to give or withhold informed consent despite being a supported patient is an important step forward in the affirmation of the rights of

individuals with mental illness. It also correctly identifies capacity as decision-specific. This idea could be incorporated into many laws concerning the rights of persons with disabilities and would do much to maximize the realization of their capacity and rights. The move away from a binary view of capacity, supported by some parts of the IMHA, is undoubtedly a positive one but an adequate review process must be retained.

Three important administrative issues arise which, if addressed, could further improve the new legislation. First, additional clarity could be added on the qualifications of individuals who can determine mental disorder. Second, other Indian legislation needs to be revised and updated to bring it in line with the new IMHA (e.g. the Medical Termination of Pregnancy Act, 1971). Third, and most importantly, consideration should be given to statutory collection of statistics about individuals receiving treatment, types of treatments being received, etc.

Overall, it is likely that India's new mental health legislation will impact on more individuals than any other piece of mental health legislation in the world [62]. It is a carefully constructed document that addresses many of the needs of individuals with mental health problems. While clarification and change are certainly needed in specific areas, other countries revising their legislation would undoubtedly benefit from studying India's constructive, pragmatic and enlightened approach to this matter.

Abbreviations

BPAD: bi-polar affective disorder; CMHA: Central Mental Health Authority; DALY: disability-adjusted-life-years; ECT: electro convulsive therapy; IMHA: Indian Mental Healthcare Act; MHRB: Mental Health Review Board; RPDA: Rights of Persons with Disability Act; SMHA: State Mental Health Authorities; UN: United Nations; CRPD: Convention on the Rights of Persons with Disability; WHO: World Health Organization; WHO-RB: World Health Organization resource book on mental health, human rights and legislation.

Authors' contributions

The analysis and writing of the paper were preformed by RMD who was supervised in all stages by BDK who revised various drafts of the paper. Both authors read and approved the final manuscript.

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The authors declare that they have no competing interests.

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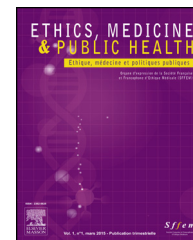
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DOSSIER ‘‘PRIVACY: DEFINITION, PROTECTION AND PROJECTION’’
Studies

Privacy, confidentiality and carers: India’s harmonisation of national guidelines and international mental health law



Intimité, confidentialité et aides sociales : l’harmonisation des recommandations nationales en Inde et des lois internationales de santé mentale

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Summary

Context. — Clear guidelines on confidentiality and privacy are essential for those receiving treatment from mental health services and their families. Good mental health care also requires suitable supporting legislation. The United Nations Convention on the Rights of Persons with Disability (UN-CRPD) seeks to protect the rights and freedoms of individuals with disabilities. Its remit includes those with long-term mental or intellectual impairments. Consequently, many of the 159 signatories to the convention are attempting to revise their mental health legislation to bring it in line with the UN-CRPD. The World Health Organisation Resource Book on Mental Health, Human Rights and Legislation (WHO-RB) provides guidelines for drafting and revising mental health legislation. This document includes a checklist detailing topics, which should be addressed, but some elements of the WHO-RB appear to be in conflict with the UN-CRPD. This paper explores the UN-CRPD and the WHO-RB with specific focus on their positions on confidentiality, privacy and the rights of care-givers. We consider how the Indian Mental Healthcare Bill 2016 (IMHB) attempts to harmonise these two perspectives.

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Methods. — References to privacy, confidentiality and carers were identified and compared in the UN-CRPD, WHO-RB and IMHB. In addition to this, eleven items were identified in the WHO-RB Checklist relating to privacy, confidentiality and carers. The IMHB was analysed to see if it was concordant with these items.

Results. — All three documents (UN-CRPD, WHO-RB and IMHB) refer to privacy, confidentiality and care-givers. The consideration of privacy in the WHO-RB was comprehensive; the UN-CRPD and the IMHB by contrast, affirm privacy as a right but fail to explore it in detail. The consideration of family and care-givers is starkly contrasted in the three documents. The UN-CRPD gives consideration to a person's right to have a family but makes little direct reference to the role of family in delivering care or supporting capacity. Regarding care-givers and family's quality of life, it briefly considers the material consequences of caring for an individual with disability, but fails to consider the psychological impact of such care-giving or how further exploration of confidentiality and privacy could ameliorate some of these stressors. The IMHB is adherent with five out of the eleven items (45.4%) drawn from the WHO-RB's checklist relating to privacy, confidentiality and carers. The IMHB attempted to address the others using its construct of nominated representatives and we identify some of the limitations of this concept in our discussion.

Conclusion. — The UN-CRPD affirms the key fundamental principles of privacy and confidentiality, but its consideration of these principles lacks the depth required to address the complex and varied issues that can arise in the realm of mental health. The UN-CRPD fails to consider the role of the family and carers in sufficient detail. Confidentiality, privacy and the complex role of family are, however, discussed in the WHO-RB and this document can greatly supplement the UN-CRPD. This is especially true in instances when temporary limitation of specific rights is required. The IMHB has incorporated the UN-CRPD principles and applied them to mental health, and, in doing so has addressed many of the issues raised by the WHO-RB.

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MOTS CLÉS

Confidentialité ;
Handicap ;
Recommandations ;
Santé mentale ;
Intimité

Résumé

Contexte. — Des lignes directrices claires sur la confidentialité et la vie privée sont indispensables pour ceux recevant des traitements de services de santé mentale ainsi que leurs familles. Des soins de santé mentale de qualité requièrent aussi un corpus juridique approprié. La Convention des Nations-Unies relative aux droits des personnes handicapées (CNUDPH) vise à protéger les droits et les libertés des personnes handicapées. Elle protège aussi les personnes qui présentent des incapacités mentales et intellectuelles durables. Par conséquent, ses 159 signataires cherchent à modifier leur législation sur la santé mentale afin de l'aligner sur la CNUDPH. L'ouvrage de référence de l'Organisation mondiale de la santé sur la santé mentale, les droits de l'homme et la législation (OR-OMS) fournit des orientations pour rédiger et réviser les lois sur la santé mentale. Ce document comprend une liste de sujets qui doivent être couverts par la loi. Certains aspects de l'OR-OMS semblent cependant en conflit avec la CNUDPH. L'objet de cette étude est d'analyser la CNUDPH et l'OR-OMS en se concentrant en particulier sur leur traitement de la confidentialité, de la vie privée et des droits des personnels soignants. Nous nous fonderons sur la loi indienne de 2016 régissant les services de santé mentale (*Indian Mental Healthcare Bill 2016* — IMHB) et sa tentative d'harmoniser ces deux approches.

Méthode. — Relever et comparer les références faites à l'intimité, la confidentialité et la carrière des personnels soignants dans la CNUDPH, l'OR-OMS et l'IMHB. De plus, onze points faisant référence à la vie privée, la confidentialité et la carrière des personnels soignants ont aussi été relevé dans la liste de contrôle de l'OR-OMS. Une analyse de l'IMHB a été menée afin de voir si cette loi concorde sur ces points.

Résultats. — Les trois documents mentionnent la vie privée, la confidentialité et les personnels soignants. Dans l'OR-OMS, l'examen de la vie privée est exhaustif ; la CNUDPH et l'IMHB par contre, bien qu'affirmant le droit à la vie privée, ne l'expliquent pas en détail. La notion de famille et de personnels soignants est très variable selon les documents. La CNUDPH mentionne le droit d'une personne d'avoir une famille mais ne mentionne directement que très peu le rôle de la famille en tant que soutien et dans la prestation des soins. En ce qui concerne la qualité de vie des pourvoyeurs de soin et de la famille, les conséquences matérielles liées

au fait d'avoir la charge d'un enfant handicapé sont brièvement mentionnées. Mais l'impact psychologique d'une telle prestation de soin n'est pas abordé. Et la question de savoir comment un encadrement plus strict de la confidentialité et de la vie privée pourrait atténuer certains des facteurs de stress n'est pas examinée non plus. L'IMHB est en conformité sur cinq des onze points (soit 45,5 %) tirés de la liste de l'OR-OMS sur la vie privée, la confidentialité et les carrières des personnels soignants. L'IMHB tente de résoudre les autres points en instaurant un représentant nommé et les limites de ce mécanisme sont présentées dans la discussion.

Conclusion. — La CNUDPH confirme les principes fondamentaux du droit à la vie privée et à la confidentialité. L'attention portée à ces principes n'est cependant pas suffisamment approfondie pour répondre à la variété et la complexité des questions qui peuvent émerger dans le domaine de la santé mentale. La CNUDPH omet d'envisager suffisamment précisément le rôle de la famille et des personnels soignants. La confidentialité, la vie privée et le rôle complexe de la famille sont toutefois abordés dans l'OR-OMS, cet instrument devenant un complément important de la CNUDPH. Cela est d'autant plus vrai lorsque des restrictions provisoires de droits spécifiques sont nécessaires. L'IMHB a intégré les principes de la CNUDPH et les a appliqués à la santé mentale, lui permettant ainsi de résoudre de nombreux problèmes posés par l'OR-OMS.

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Introduction

Confidentiality and privacy generate many practical ethical issues in medicine in general and in psychiatry in particular. These ethical issues are addressed and informed by national and international laws, among other factors. Recent interpretations of international legislation appear to be at odds with widely accepted national standards in certain respects [1], and modern international human rights conventions have highlighted various inadequacies in national mental health legislation [2,3].

Many countries are currently revising their mental health laws to bring them in line with these international standards [4,5]. One such country is India, which is in the process of adopting new mental health legislation [6]. This paper identifies international standards that pertain to confidentiality and privacy and explores how Indian legislators have attempted to be concordant with these standards while addressing the practical needs of Indian citizens.

International law on mental health

International human rights law is a relatively new concept [7]. One of the roles of international mental health law and standards is to guide and influence national mental health law. The preeminent international document concerning mental health law is the United Nations Convention on the Rights of Persons with Disabilities (UN-CRPD) [8]. The UN-CRPD was first adopted by the UN in 2006 [9]. One hundred and sixty states have signed the convention, the vast majority of which have also ratified it. Countries, which have yet to ratify the convention, include USA, Netherlands and Ireland. The UN-CRPD contains 50 articles, with Articles One to 30 pertaining to general principles, providing protections against discrimination and safe-guarding rights and freedoms. Articles 35 to 50 consider the implementation of such legislation on an international level.

Article One of the Convention includes people with long-term mental and intellectual impairments within its remit. Many see this inclusion as a positive step to reduce stigma among those affected by mental illness [3]. This has,

however, significant legislative implications for ratifying states. For example, the incorporation of individuals with mental health issues within the convention is clouded by the UN-CRPD's failure to define key terms, including mental or intellectual impairment [10]. Hoffman et al. have suggested that the UN-CRPD has created a cultural shift in perceptions of mental illness in Canada, but add that active legislation is needed, rather than passive adoption of its ideas [5]. Active legislative reform is precisely what India is seeking to do with its new Mental Healthcare Bill [11], which is considered in greater detail in this paper.

The World Health Organisation Resource Book on Mental Health, Human Rights and Legislation (WHO-RB)

The WHO-RB was first published in 2005 under the direction of the WHO's Department of Mental Health and Substance Abuse [12]. Input and feedback were received from authors all over the world. The WHO-RB aims to facilitate countries in developing, adopting and implementing high quality mental health law. The WHO-RB is divided into three sections. First, it explores the context of mental health law; second, it discusses what should be contained in mental health law; and finally, it considers practicalities of drafting, adoption and implementing such law. The items that should be contained in mental health law are summarized in Annex one of the WHO-RB in the *WHO Checklist on Mental Health Legislation*. This checklist has previously been used in research in mental health law [13,14]. Kelly especially explored mental health legislation in England, Wales and Ireland using the WHO-RB's checklist as a guideline [14]. For the present paper, eleven principles concerning confidentiality, privacy and the role of family were identified within the checklist; these are explored in the results section.

The WHO-RB acknowledges that issues relating to mental health can be either covered by dedicated mental health legislation or integrated into other relevant areas of legislation or policy. For example, laws preventing employment discrimination based on mental illness, could be included in mental health legislation, employment legislation, or

equality legislation. Consequently, national or regional mental health law might not address all the relevant issues directly. This is an important consideration when analyzing the IMHB and its concordance with the WHO-RB checklist items, as we do in this paper.

More specifically, the mental health policy of any given country creates a key context for its mental health laws, with the result that the ways in which the requirements of the WHO-RB are met or not met in India may differ from the ways in which its requirements are met or not met in other countries. Issues of local tradition, structure of services, funding models, and overall health status are all highly relevant to the extent to which mental health law meets international standards, reflects population mental health need, generates positive change, and promotes the rights of the mentally ill on the ground. That said, however, legislation always has an important role to play, and that is why we have chosen to focus this paper on the highly innovative Indian Mental Healthcare Bill (IMHB).

Indian Mental Healthcare Bill (IMHB)

India is the second most populous country in the world with over 1.25 billion inhabitants. India is currently in the process of adopting a new mental healthcare legislation. The IMHB 2016 was passed by the Rajya Sabha (the upper house of the Indian government) in August 2016. This Bill has been greatly anticipated [6,11,15,16] and will replace the Mental Health Act 1987.

The proposed Indian Mental Healthcare Act is one of the first pieces of mental healthcare legislation that is drafted explicitly to conform to the UN-CRPD. Against this background, the present paper focuses on the Indian bill and its relationship with the WHO-RB and UN-CRPD, with focus on issues relating to confidentiality and privacy.

Methods

All references to confidentiality and privacy in the WHO-RB, UN-CRPD and IMHB were identified. In addition, in order to analyse the application of principles concerning confidentiality and privacy, all references to family, care-givers, relatives and friends were also identified. Relevant sections of the three documents were identified and contrasted; similarities, omissions and points of conflict were explored.

All items from the WHO-RB checklist were reviewed; eleven were identified that related to confidentiality, privacy and the role of carers and family. The IMHB was evaluated to establish if it legislated for these suggested topics. For this analysis, the Mental Healthcare Bill, 2016 as passed by the Rajya Sabha on the 8th of August was used.

In our analysis, specific items from the WHO-RB were classified as either present or absent in the IMHB (i.e. in a binary fashion). This was in line with previous studies, which have used the WHO-RB Checklist [14], and in line with the focus of the present paper, which is on the *legal* framework pertaining to mental health, rather than mental health policies.

Results

All three documents (the UN-CRPD, WHO-RB and IMHB) refer to both privacy and confidentiality (Table 1). All three advocate for privacy and confidentiality, and consider the ethical implications of large amounts of personal data being stored on computers.

The UN-CRPD, in particular, seeks to ensure confidentiality for individuals with disabilities. Article 22 protects the respect for privacy on a day-to-day basis, while Article 31(1)(a) addresses privacy relating to the collection of data and statistics. The UN-CRPD makes no mention of occasions when the right to confidentiality can be limited. The WHO-RB, by contrast, sets out 5 contexts in which it may be reasonable to breach confidentiality. These are:

- life threatening emergencies;
- risk of serious harm to self or others;
- preventions of morbidity or serious suffering;
- in the interest of public safety;
- by court order.

In line with this, Clause 23 of the IMHB sets out criteria on which confidentiality can be broken. These criteria include the five circumstances detailed by the WHO-RB (above) as well as the two following items:

- releases to a nominated representative to fulfil their role;
- release to other health care professionals to aid them in delivering health care.

While privacy is affirmed in all three documents, it is only explored in significant detail in the WHO-RB. The WHO-RB identifies at least four types of privacy: information privacy, bodily privacy, privacy of communication and territorial privacy. It considers limitations of the right to privacy in the context of resource shortage and emergency situations – a practical consideration not covered in the other documents. The WHO-RB also considers the importance of privacy in different settings, distinguishing the acute from the residential setting. The IMHB affirms the right to privacy in Clause 20(2), which pertains to protection from cruel, inhumane or degrading treatment. The implications of considering it in this context are discussed below.

All documents (the UN-CRPD, WHO-RB and IMHB) refer to family and care-givers and these findings are summarised in Table 2. While the UN-CRPD mentions family, it does so in a very different context and does not explore the practical application of its principles concerning privacy and confidentiality in the context of family. One of the guiding principles of the UN-CRPDs Preamble [Subsection (x)] is that “the family is the natural and fundamental group unit of society and entitled to protection by society and the state”. However, the discussion of family only focuses on ensuring that the individual has a right to a family life free from external interference.

Other references to family in the UN-CRPD pertain to raising awareness of the rights of persons with disabilities (Article 8), the right to non-interference with the family (Article 22), and the right to have a family, family life and access to family planning (Article 23). Even so, it fails to consider many of the ethical issues that often arise in psychiatry.

Table 1 Analysis of references to privacy and confidentiality in the United Nations Convention on the Rights of Persons with Disabilities (UN-CRPD), the World Health Organisation Resource Book on Mental Health, Human Rights and Legislation (WHO-RB) and the Indian Mental Healthcare Bill (IMHB).

Analyse des références à la vie privée et à la confidentialité dans la Convention des Nations-Unies relative aux droits des personnes handicapées (CNUDPH), dans l'ouvrage de référence de l'Organisation mondiale de la santé sur la santé mentale, les droits de l'homme et la législation (OR-OMS) ainsi que dans la loi indienne régissant les services de santé mentale (Indian Mental Healthcare Bill 2016 – MHB).

Document	Count	Relevant sections	Summary of position
UN-CRPD	1 Confidentiality 4 Privacy 5 Private (none relevant)	Article 22 Article 31	Protection of personal privacy for persons with disability Protection of confidentiality during the collection of statistical and research data
WHO-RB	51 Confidentiality 37 Privacy 9 Private (relevant uses only)	1.3 1.3.3 2.5.1 2.5.3.2 2.6 2.13.4 2.17.2	General protection of the right to privacy and confidentiality Protection of the right to privacy in the in-patient setting Right to confidentiality about themselves, their illness and treatment Penalties for the breach of confidentiality Cultural considerations and the rights of family to information Situations in which confidentiality may be breached and limitations on such disclosures The right to appeal the release of information Discussion on types of privacy in different settings (long stay versus short stay) Consideration of privacy in areas with limited income Balancing of privacy with safety Balancing the respect of privacy with the safety of the patient and others Specific consideration of women and their needs for privacy and confidentiality
IMHB	5 Confidentiality 0 (relevant) Private, 1 Privacy	20(2)(d), 23 24(2)	Affirming the right to privacy and confidentiality Lays out six grounds on which confidentiality can be breached Protection of digital data confidentiality
Search terms: confidentiality, privacy, private.			

Indeed, an overly literal or inflexible application of the Article 22 right to respect for privacy could arguably result in the contravention of other articles of the UN-CRPD. For example, failure to breach confidentiality at times may result in a loss of dignity (Article 3), death (Article 10), loss of liberty (Article 14), exploitation or violence (Article 16), or loss of health (Article 25). This highlights UN-CRPD's chief weakness in the context of psychiatry; namely, that it was not designed specifically for psychiatry but rather for disabilities as a whole.

Section 2.6 in the WHO-RB has the most in-depth discussion of the role of family and the rights of that family to information. It suggests that family and carers have a right to information needed to carry out their role as carers. It also rejects the idea that legislation should arbitrarily refuse carers access to information on the grounds of confidentiality. This section also discusses the need to take cultural factors into account in these matters.

The IMHB goes some way to comply with this. It offers services to support the family of persons with mental

illness, particularly in Clause 18(4)(c). The family is seen as a significant support for the mentally ill individual and the family home is often seen as the primary place for treatment. Clause 98 discusses the important role of the family in discharge planning and their right to information in this context.

Table 3 summarises the IMHB's concordance with the items from the WHO-RB checklist that pertain to confidentiality and privacy as applied in the context of carers and family. These selected items from the WHO-RB provide a useful assessment of the protection of privacy and confidentiality in the emerging mental health legislation. The IMHB was concordant with 45.4% (5/11) of the identified WHO-RB Checklist items in this context.

The IMHB considers offences and penalties for breaching of the Bill but no specific consideration is given to breaches of confidentiality, as suggested in the WHO-RB checklist. Importantly, however, the IMHB considers breaches by both individuals and companies, and this is particularly significant when large amounts of information are stored electronically,

Table 2 Analysis of references to family and carers in the United Nations Convention on the Rights of Persons with Disabilities (UN-CRPD), the World Health Organisation Resource Book on Mental Health, Human Rights and Legislation (WHO-RB) and the Indian Mental Healthcare Bill (IMHB).

Analyse des références à la famille et aux personnes soignants dans la Convention des Nations-Unies relative aux droits des personnes handicapées (CNUDPH), dans l'ouvrage de référence de l'Organisation mondiale de la santé sur la santé mentale, les droits de l'homme et la législation (OR-OMS) ainsi que dans la loi indienne régissant les services de santé mentale (Indian Mental Healthcare Bill 2016 – IMHB).

Document	Count	Relevant section	Summary of position
UN-CRPD	13 Family	Preamble	Family is the fundamental unit of society
	1 Care-givers	Article 8	Respect for privacy in the context of the family
	6 Families	Article 16	Right to have a family
	3 Relatives	Article 22	Right to family life
		Article 23	Information, services and supports for the families of children with disabilities
		Article 28	Right to an adequate standard of living for people with disabilities and their families
WHO-RB	111 Family	Preface	Consideration of how close a patient is to their family and its implication on breaching confidentiality
	67 Families	1.3.3	The need to share information with family members, especially in the case of emergency powers being used
	28 Carers	2.3.1	Patients right to communicate with friends, family and carers
	8 Friends	2.5.1	The cultural considerations in the relationship between family and confidentiality
	3 Spouse	2.5.3.3	Rights of care-givers to receive information to aid them in their supportive role
		2.5.4	Family members rights to appeal decisions regarding mental health care and appeal for discharge
		2.6	Role of family in seeking treatments for a patient
		2.7.3	Consideration of proxy consent by family members in certain situations
		2.7.4	Discussion of definition of family
		2.8.3.3	Family role in drafting and reviewing legislation
		2.8.3.5	
		2.8.3.6	
		2.8.4.1	
		2.13.3	
		2.14.2	
		2.14.3.4	
		2.15.2.2	
		2.17.1	
IMHB		3.2	
		3.2.4	
	16 Family	11(1)	Care-givers role concerning advance directives
	14 Care-giver	18(2)	Care-givers will have a role in evaluating the acceptability of mental health services
	10 Relative	11(11)(iii)	Acknowledges the social health and economic burden of mental illness on carers
	1 Friends	18(4)(c)	Mental health services should support the family of persons with mental illness
		98(1)	The inclusion of family members of care-givers in discharge planning if they will be living with them
		100(7)	Family to be contacted if a person with mental illness is found wandering or homeless

Search terms: family, families, care-givers, relatives, spouse, friends, carers.

opening the possibility of research studies using big data [17,18].

When considering the role of family in the IMHB, it is important to understand the role of nominated representatives. This, fundamentally, is a mechanism for partially realising some of the principles suggested by the WHO-RB checklist relating to families' rights. The IMHB's provisions are not, however, in full concordance with the WHO-RB checklist owing to various restrictions within the provisions.

For example, under the Indian bill, individuals with mental illness have a right to make an advance directive (Clause 5) and can specify whom they would like to be their nominated representative (Clause 5(1)(c)). This might not be a family member and provision of information to the nominated representative may replace provision of information to the family, thus diminishing family involvement.

If no nominated representative is suggested by advance directive, Clause 14(4) allows a family member, care-giver

Table 3 Indian Mental Healthcare Bill (IMHB) compliance with the World Health Organisation Resource Book on Mental Health, Human Rights and Legislation (WHO-RB) guidelines pertaining to privacy and confidentiality.
Conformité de la loi indienne régissant les services de santé mentale (Indian Mental Healthcare Bill 2016 — IMHB) avec l'ouvrage de référence de l'Organisation mondiale de la santé sur la santé mentale, les droits de l'homme et la législation (OR-OMS) recommandations concernant la vie privée et la confidentialité.

Legislative issue	WHO-RB checklist item	IMHB compliant with the WHO-RB	Relevant section in the IMHB
Is the right to patients' confidentiality regarding information about themselves, their illness and treatment included?	D2	Yes	23(1) 24(1) 24(2)
Are there sanctions and penalties for people who contravene patients' confidentiality?	D2a	No	108 109
Does the legislation lay down exceptional circumstances when confidentiality may be legally breached?	D2b	Yes	23(2)
Does the law insist on the privacy of people with mental disorders?	D6	Yes	20(2)(d)
Is the law clear on minimal levels of privacy to be respected?	D6a	No	20(2)(d)
Does the law entitle families or other primary carers to information about the person with a mental disorder (unless the patient refuses the divulging of such information)?	E1	No	17(d) 89(13) 98(1) 100(7)
Are family members or other primary carers encouraged to become involved in the formulation and implementation of the patient's individualised treatment plan?	E2	No	14(4)(b–c) 17 98(1)
Do families or other primary carers have the right to appeal involuntary admission and treatment decisions?	E3	No	17(h) 77(1) 89(10) 90(14)
Do patients, family members and personal representatives have the right to appeal against emergency admission/treatment?	M7	No	77(1) 94(1)
Does the law lay down adequate procedures for the use of seclusion and restraints, including: . . . that family members/carers and personal representatives be immediately informed when the patient is subject to seclusion and/or restraint?	P6	Yes	97(5)
Where a person is unable to give informed consent (and where a decision has been made that research can be conducted): Does the law ensure that proxy consent is obtained from either the legally appointed guardian or family member. . . ?	Q2a	Yes	99(3)

or an individual selected by the Mental Health Review Board to be appointed. The roles of nominated representative are:

- to consider the current and past wishes, history, values, culture and best interests of the individual and give credence to these views in decisions;
- support the person with mental illness in making decisions;
- seek information on diagnosis and treatments to help support the individual;
- involvement in discharge planning;
- apply for admission if necessary;
- appeal the decision to admit the patient in a supported (involuntary) admission;
- protect and appeal for the right of the person with mental illness;
- consider giving consent for research if the patient is unable to do so.

These provisions, although imperfect, do at least try to preserve privacy and confidentiality to as great an extent as possible, while also satisfying many of the important family issues raised by the WHO-RB. This concept is explored in greater detail in the Discussion section of this paper (below).

Discussion

Privacy

The WHO-RB expands on the topic of privacy in a way that the other two documents do not. Its consideration of different types of privacy provides a perspective that is sadly lacking in medical literature more generally, which is strongly focused on data privacy to the virtual exclusion of all else. The WHO-RB highlights how a more informed and balanced position on privacy is necessary. This would hold

in tension *all* the rights of the individual affected by mental illness, not just their rights to privacy and confidentiality. Most importantly, it also considers the rights of the family.

The importance of privacy is also duly identified in the IMHB, which affirms the right to privacy by referencing the right to protection from cruel, inhumane or degrading treatment. This is a reference to Article 15 of the UN-CRPD and Article 5 of the Universal Declaration of Human Rights [19], both of which affirm the right to freedom and protection from cruel inhumane or degrading treatment or punishment.

As discussed above, however, while many rights are limited on occasion (e.g. to protect individuals or other rights), the right to freedom from torture or cruel, inhuman or degrading treatment or punishment is one of the fundamental, non-derogable human rights [20]. Consequently, if this is the basis for the right to privacy, then limitation of privacy could be seen as unacceptable in any context.

The WHO-RB, by contrast, highlights how complex and nuanced the right to respect for privacy can be, as it discusses the practical limitations and potential dangers of ensuring privacy at all times. This has significant implications for viewing privacy as a non-derogable right. The failure of the UN-CRPD to elaborate on the definition, parameters, implementation and implications of privacy might leave patients in a vulnerable situation in respect of other rights.

Confidentiality

The UN-CRPD is in many ways uncompromising about the right to confidentiality and privacy. Freeman et al. have highlighted how an overly dogmatic interpretation of the UN-CRPD can actually limit the rights of individuals with mental illness [1]. Canadian clinicians have also highlighted various difficulties and challenges in striking a balance between information sharing and confidentiality, and have identified that resource limitations further complicate these issues [21]. Carasevici also identifies some of the tensions that arise in psychiatry, as there may be pressure to breach confidentiality for the good of society or, indeed, in the best interest of the patient [22]. Again, the WHO-RB identifies contexts in which confidentiality can be breached and these are expanded on in the IMHB.

Article 28 of the UN-CRPD, which addresses the standard of living of the individual with disability and their family, may allow for consideration of instances where rights relating to privacy and confidentiality could be limited to allow for the standard of living of the family to be improved. This article is, however, predominantly focused on material goods rather than the psychological impact the illness could have on the family.

Family and carers

Regarding the rights of family members, the IMHB aligns itself more with the UN-CRPD and does not consider in detail the rights of family to information. The two occasions where the right of family to information is considered pertain to (a) when a patient is being discharged to reside with a caregiver or family member (Article 98(1)) and (b) when a person is homeless or found wandering (Article 100(7)).

As already discussed, the IMHB attempts to address many of the issues raised by the WHO-RB checklist concerning confidentiality through the appointment of a nominated representative. This mechanism can facilitate information sharing, while maintaining a significant degree of confidentiality. This mechanism however has several limitations:

- advance directives allow for the individual to appoint anyone to be their nominated representative; this may deprive carers or family members of important information or to have input concerning treatment or discharge. While this may be often very appropriate, it may also prove problematic;
- a person who has appointed a nominated representative may revoke or alter such appointment at any time;
- the Mental Health Review Board may revoke an appointment made by an individual if they do not feel that it is in their best interests;
- conflicts which arise within the family as to treatment options may not be reflected by a single-family member acting as a nominated representative.

Conclusion

The UN-CRPD, WHO-RB and IMHB demonstrate varying levels of consideration of the themes of privacy, confidentiality, and the role of family in mental healthcare. The expansive nature of the WHO-RB document allows for the most comprehensive exploration of these themes. The UN-CRPD's inclusion of individuals with mental illness fails to consider adequately the particular challenges encountered in the context of mental illness. These are, however, considered by the WHO-RB and have duly informed the IMHB, at least to a certain extent. As the WHO-RB articulates, privacy is a complex concept with many different domains, and it requires deeper consideration in both the IMHB and, especially, the UN-CRPD, as well as in the medical literature as a whole.

The UN-CRPD, for example, advocates for privacy and confidentiality and makes no provision for carers or family members to have information. It presents a sparse discussion of contexts where information privacy can be breached in the case of persons with disabilities only "on an equal basis with others". This would suggest that breaching confidentiality due to disability (e.g. mental illness) would be unacceptable but that breaching confidentiality due to risk posed to self, others or society, or due to a court order may be acceptable. It is not clear how this would work in practice: what if the risk is attributable to the 'disability' (i.e. mental illness)?

In the IMHB, confidentiality is the most carefully considered principle of the three key principles explored in this paper; i.e. privacy, confidentiality, and the role of family. Although the legislation is far from exhaustive on this theme, the right to privacy is affirmed, albeit that insufficient consideration is given to the practical realisation of this right. This leaves patients exposed to potential abuses of their right to privacy.

The proposed Indian legislation could also be seen to be in breach of the UN-CRPD considering the exceptions it lays out to the rights to privacy and confidentiality. The UN-CRPD, however, must be read; many articles can only be upheld through the partial and temporary limitation of other rights.

For example, in the context of mental illness, the right to life (Article 10) may necessitate the temporary limitation of the right to confidentiality and privacy (Article 22). On this basis, the optimal realisation of the rights of individuals with mental illness can involve the occasional limitation of certain other rights in certain circumstances. The IMHB is a good example of how legislation can minimise the extent and duration of any such limitations.

The IMHB also gives consideration to the role of families and care-givers and their inclusion in an individual's treatment. The role of cares and family is more carefully considered than is required by the UN-CRPD. Nonetheless, certain elements of the IMHB could be perceived as at odds with the UN-CRPD, as the rights of the family to information and involvement with treatment are very limited outside of the role of nominated representative.

Overall, however, the IMHB has incorporated many of the UN-CRPD principles and applied them to mental health and, in doing so, it has also addressed many of the issues raised by the WHO-RB. The Indian legislation also now leads the world in seeking to find a balance between the rhetoric of international human rights and the pragmatic provision of care in specific social, community and family contexts.

One of the key limitations on the IMHB achieving its full potential, however, will relate to its practical implementation in practice. As is inevitable in a country as large as India, there is considerable variation in levels of mental health care provided in different areas. As a result, there is a strong need for further consideration of the possibility of phased implementation of the new law in line with different regions' states of readiness for change of this magnitude. This needs to be underpinned by careful research into optimal models of policy change to accord with the law, and establishing ways of ensuring that any possible paradoxical effects are minimised, so that the potential benefits of the new law are realised as fully as possible for the betterment of the mentally ill and their families.

Disclosure of interest

The authors declare that they have no competing interest.

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BRIEF RESEARCH COMMUNICATION

New legislation, new frontiers: Indian psychiatrists' perspective of the mental healthcare act 2017 prior to implementation

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ABSTRACT

Context: The mental healthcare act 2017 represents a complete overhaul of Indian mental health legislation.

Aims: The aim of this study was to establish the opinions of Indian psychiatrists regarding the new act.

Settings: Mental health professionals in Bihar and Jharkhand were interviewed.

Design: A focus group design was utilized.

Materials and Methods: Key questions explored the positive and negative aspects of the act and the management of the transitional phase. All focus groups were recorded and transcribed.

Analysis: Data were coded and analyzed using an inductive approach.

Results: Many positive aspects of the new legislation were identified especially relating to rights, autonomy, and the decriminalization of suicide. However, psychiatrists have significant concerns that the new legislation may negatively impact patients and increase stigma. Psychiatrists held varying views on the proposed licensing and inspection of general hospital psychiatric units.

Conclusions: Careful evaluation of the new legislation is needed as the concerns raised warrant ongoing monitoring.

Key words: Ethics, focus groups, human rights, jurisprudence, Mental Healthcare Act 2017, stigma

INTRODUCTION

In 2018, India plans to implement the mental healthcare act (MHCA) 2017. This is a long-anticipated piece of legislation.^[1] The major catalyst for the new act was the United Nations' convention on the rights of persons with disability (UNCRPD),^[2] which India ratified in 2007. This placed a onus on India to bring its legislation in line with

the UNCRPD. From a theoretical perspective, the MHCA is a highly progressive piece of legislation, concordant with a higher proportion of the world health organization human rights standards^[3] than current legislation in England and Wales.^[4,5] It remains to be seen how this legislation will work in practice.

Aims

In this study, we aim to:

1. Identify the perceived benefits of the MHCA
2. Identify concerns regarding the act's content

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3. Identify issues relating to implementation.

Setting and design

Focus groups were held at the initial stage of a larger research project conducted by “our institution.” This project plans to examine the views of Indian psychiatrists about the new legislation. The three focus groups reported here were conducted in Bihar and Jharkhand in late 2017, before the implementation of the MHCA. A theoretical sampling method was used.^[6]

MATERIALS AND METHODS

Focus groups had two moderators; the first leads the discussion, while the assistant was responsible for audio recording, note-taking, and logistics. Recordings were transcribed. The four main questions analyzed were as follows:

- 1. What is positive about the new legislation?
- 2. What are your concerns about the new legislation?
- 3. What needs to be done in the transitional phase?
- 4. What would you have done differently if you were writing the act?

Participants included 20 mental health professionals (16 psychiatrists, and the head of the department for social work, nursing, psychology, and occupational; 8 psychiatrists worked solely in the private sector) spread over the three focus groups. Focus groups lasted between 45 and 75 min. Ethical approval was granted by Trinity College Dublin School of Medicine’s research ethics committee.

Analysis

After each focus group, the researchers reviewed the focus group, refined the questions, and critiqued the interview process, as part of an iterative process.^[7] Recorded data were transcribed and combined with the observer’s notes. Data analysis employed an inductive approach.^[8] Focus group participants were not involved in data analysis.

RESULTS

The main perceived benefits and potential concerns identified by the participants are summarized in Table 1. Not only increased patient autonomy was generally seen as a positive development but also raised a number of concerns. These included the possibilities of patients refusing treatment, psychiatrists being held responsible for adverse outcomes, and underutilization of advance directives.

Some differences were noted between the varying groups of psychiatrists. Most psychiatrists who worked in public mental health hospitals tended to welcome the registration of general hospital psychiatric units (GHPUs), while others were concerned that inspection of these facilities would discourage the opening of GHPU.

Table 1: Key potential benefits and concerns about the Mental Healthcare Act 2017 and the relevant sections of the Act

Issue raised	Relevant sections of the Indian Act
Positive comments	
Decriminalization of suicide	Sections 115
Regulation and licensing of general hospital psychiatric units	Sections 65-72
Increased focus on human rights	Sections 18-28
Legal position of allied health professionals	Sections 2g, q, and x
Increased patient autonomy	Sections 4, 5-13, 20-25
Negative comments	
Regulation and licensing of general hospital psychiatric units	Sections 29p, 65-72
Banning of unmodified ECT	Section 95 (1a)
Underrepresentation of psychiatrists on the MHRBs, SMHAs and CMHA and concern about the level of experience of other participants	Sections 34, 46, 74
The practicalities of nominated representatives and possible exclusion of families	Sections 14-17
A widening treatment gap due to increased emphasis on autonomy and advance directives	Sections 4, 5-13
Concerns about being liable if rights cannot be realized	Sections 107-108

ECT – Electro-convulsive therapy; MHRBs – Mental Health Review Boards; SMHAs – State Mental Health Authorities; CMHA – Central Mental Health Authority

Psychiatrists, who worked primarily in private settings, were troubled that this legislation placed an added onus of responsibility on them whereas those who worked primary in public or Government settings felt that the MHA placed the burden of providing healthcare on the shoulders of the Government.

Psychiatrists employed by the state were more convinced of the benefits of recognizing allied health professionals in the legislation. However, individuals in all focus groups were concerned about the place of allied health professionals and resulting underrepresentation of psychiatrists, on the central mental health authority (CMHA), the state mental health authorities (SMHAs), and the mental health review boards (MHRBs).

Probing the motivation behind the criticism revealed that concerns about patient care were the key motivating factor, even on issues that appeared to relate to reduced powers for psychiatrists. For example, concerns about the banning of unmodified electroconvulsive therapy (ECT) related to patients being deprived of life-saving interventions due to resource limitation.

Regarding implementation, all groups raised grave concerns about resource issues, in particular, how the new legislation may increase administrative work and reduce patient contact.

DISCUSSION

In general, there was a clear consensus on many topics. The two areas where there were more conflicting views related to GHPUs and individual autonomy.

GHPUs are clearly a key part of Indian psychiatry, regarding both treatment^[9] and research.^[10] These units have not been subject to the same level of review as stand-alone psychiatric facilities under the 1987 legislation. Sections 65–72 of the MHCA lay provisions for the registration and inspection of all mental health establishments including GHPUs (Section 2[p]). In general, psychiatrists working in stand-alone psychiatric hospitals welcomed this inclusion.

Psychiatrists working in GHPUs or predominantly working with outpatients, however, were concerned that such regulation could make hospitals less likely to open GHPUs, necessitating individuals to seek treatment in stand-alone psychiatric hospitals. This could potentially undermine many of the principals of the UNCRPD including article 19 (concerning inclusion in the community). It could also increase institutionalization, a major concern of the UNCRPD's authors.^[11] Such a consequence would hamper national mental health policy^[12,13] and potentially undo recent progress.^[14] Inspection and review processes are essential in all areas of medicine including psychiatry; hence, the impact of these new measures on stigma and institutionalization will need close monitoring.

The subject of patient autonomy provided many conflicted answers. All groups supported the addition of human right protections but were concerned that this had gone too far and that such a focus on autonomy might limit the ability to treat patients, i.e., limit the right to treatment. One psychiatrist stated, "I think it's only rights in the new Act."

Patient autonomy is supported in many ways in the MHCA. Section 4,^[3] for example, affirms patients' capacity to make treatment decisions including those perceived as inappropriate or wrong. The role of the family has been replaced in many ways with the nominated representative (giving autonomy in this area to the individuals receiving treatment),^[15] and Rao *et al.* have highlighted how this conflicts with Indian culture.^[12]

Autonomy appears to have become the unquestionable central ethical principle,^[16] and paternalism has been vilified as universally negative. The general comment on article 12 of the UNCRPD has further cemented this in the international context.^[17] Dogmatic and overly literal application of this position stands to harm individuals suffering from mental illness.^[18]

The MHA has not, however, embraced a particularly hard-line interpretation of article 12 of the UNCRPD.

Moreover, while the new legislation is a paradigm shift from the 1987 act, it still incorporates some limits to autonomy including the areas of emergency treatment (Section 94), supported admissions (Section 89), limitations on nominated representatives (Section 16), and proxy consent (Section 89^[7]).

Finally, there are two key limitations to this research. First, a greater number of participants would be helpful, and hence, more focus groups are planned for after the act is implemented. In the meantime, the small sample size limits the generalizability of results (although, it is noteworthy that consistent themes emerged in our work). Second, all focus groups were held before implementation of the act, and it is possible that (a) anticipated concerns might not materialize in practice, and (b) issues which were not identified may present significant, unexpected challenges as implementation progresses.

CONCLUSIONS

The MHCA came into effect in July 2018. Implementation will undoubtedly present many challenges. The concerns raised in this paper and elsewhere warrant careful monitoring. There is also however clear awareness that the MHCA presents unique opportunities for the development of mental healthcare in India.

Indian psychiatrists have expressed concern that individuals without clinical training will have disproportionate impact on clinical decisions under the new legislation and that psychiatrists will be underrepresented.^[19] This may happen in the case of nominated representatives, MHRBs, SMHAs, and the CMHA. This however also presents an opportunity for psychiatrists as collaborators and educators, guiding and educating family members, nominated representatives, members of review boards, and mental health authorities. The guidance of psychiatrists will be needed now more than ever, and it will be important that positions are transparent, justifiable, and carefully articulated in a manner that fosters collaboration.

The MHCA places an onus on the government to provide a sufficient level of mental healthcare, bans unmodified ECT, and places allied healthcare professionals in key strategic areas in the mental health service. All these provisions will create a need to increase staffing numbers and provide additional training to existing staff to facilitate these new roles. The demand for highly trained staff, while initially challenging, could be used to draw funding for training and recruitment on the basis of these legislative requirements.

India has taken a bold step in passing the most theoretically progressive piece of mental health legislation in the world. In addition to adhering to the UNCRPD, it provides 1.3 billion people with a justiciable right to mental healthcare. This

initiative might well prove too ambitious in certain respects and potentially impossible to realize in full. Whatever its outcomes, however, the new legislation has commanded international attention and may well become the mold for the next generation of rights-based mental health legislation.

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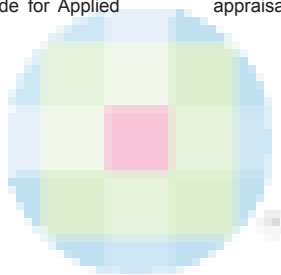
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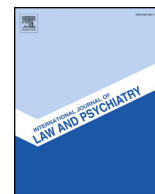
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India's Mental Healthcare Act, 2017: Content, context, controversy

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ABSTRACT

India's new mental health legislation, the Mental Healthcare Act, 2017, was commenced on 29 May 2018 and seeks explicitly to comply with the United Nations Convention on the Rights of Persons with Disabilities. It grants a legally binding right to mental healthcare to over 1.3 billion people, one sixth of the planet's population. Key measures include (a) new definitions of 'mental illness' and 'mental health establishment'; (b) revised consideration of 'capacity' in relation to mental healthcare (c) 'advance directives' to permit persons with mental illness to direct future care; (d) 'nominated representatives', who need not be family members; (e) the right to mental healthcare and broad social rights for the mentally ill; (f) establishment of governmental authorities to oversee services; (g) Mental Health Review Boards to review admissions and other matters; (h) revised procedures for 'independent admission' (voluntary admission), 'supported admission' (admission and treatment without patient consent), and 'admission of minor'; (i) revised rules governing treatment, restraint and research; and (j) de facto decriminalization of suicide. Key challenges relate to resourcing both mental health services and the new structures proposed in the legislation, the appropriateness of apparently increasingly legalized approaches to care (especially the implications of potentially lengthy judicial proceedings), and possible paradoxical effects resulting in barriers to care (e.g. revised licensing requirements for general hospital psychiatry units). There is ongoing controversy about specific measures (e.g. the ban on electro-convulsive therapy without muscle relaxants and anaesthesia), reflecting a need for continued engagement with stakeholders including patients, families, the Indian Psychiatric Society and non-governmental organisations. Despite these challenges, the new legislation offers substantial potential benefits not only to India but, by example, to other countries that seek to align their laws with the United Nations' Convention on the Rights of Persons with Disabilities and improve the position of the mentally ill.

1. Introduction

India is the second largest country in the world in terms of population and the seventh largest in terms of area. As a result, there are clear challenges delivering healthcare to India's 1.3 billion people spread across such a vast expanse (Lancet, 2017). India is ranked 154th among 195 countries for access to and quality of healthcare (GBD 2015 Healthcare Access and Quality Collaborators, 2017) and its health system continues to underperform compared to other countries, many of which are less developed (GBD 2016 SDG Collaborators, 2017). In addition, there are substantial variations between states within India (India State-Level Disease Burden Initiative Collaborators, 2017).

There are particular challenges in mental healthcare. In 2013, India had 100 million people with mental illness but just 43 psychiatric hospitals and approximately 4000 psychiatrists (Jiloha, 2015). While there have been significant advances in mental healthcare over past decades (Wig, 2015), human and financial resources remain

inadequate, with less than 1% of India's health budget devoted to mental health (Patel et al., 2016) compared to 13% of the National Health Service budget in England (Campbell, 2016). The challenges in India are diverse and complex, ranging from inadequate resourcing (Patel et al., 2016), stigma and discrimination (Singh, 2017) to perceived coercion (Raveesh et al., 2016) and variable adherence to legal formalities governing care (Subramanian, Ramanathan, Kumar, Chellappan, & Ramasamy, 2016).

1.1. Mental health legislation in India

In 2017 the World Health Organisation (WHO) emphasised the 'vital role of law' in realising the 'right to health' (WHO, 2017). Reform of law can generate significant positive change (Gostin, DeBartolo, & Katz, 2017). Up until 2018, mental healthcare in India was governed by the Mental Health Act, 1987 which was implemented in 1993 and introduced de-stigmatising terminology and revised supervision and

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admission procedures, as well as articulating certain protections of rights. It outlined a procedure for ‘admission under special circumstances’ whereby ‘any mentally ill person who does not, or is unable to, express his willingness for admission as a voluntary patient, may be admitted and kept as an inpatient in a psychiatric hospital or psychiatric nursing home on an application made in that behalf by a relative or a friend of the mentally ill person if the medical officer in charge is satisfied that in the interests of the mentally ill person it is necessary so to do’ (Section 19(1)).

Although a significant advance at the time, the 1987 Act attracted criticism in relation to a range of areas including perceived failures to reduce stigma, address the issue of wandering mentally ill people, and reduce socially sanctioned detention customs (Jiloha, 2015). Other deficiencies related to perceived lack of sufficient opportunity for patients to challenge doctors’ decisions (Sachan, 2013), legal procedures for admission and licensing of mental healthcare establishments, and inadequate support for care delivery and protection of rights (Firdosi & Ahmad, 2016). The latter came into sharp focus when the United Nations (UN), of which India is a member, adopted the Convention on Rights of Persons with Disabilities (CRPD) on 13 December 2006 and it came into force on 3 May 2008 (United Nations, 2006).

The purpose of the CRPD ‘is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity’ (Article 1). The Convention outlines a range of rights including ‘that the existence of a disability shall in no case justify a deprivation of liberty’ (Article 14). India signed the CRPD and ratified it on 1 October 2007 and, as a stated result of this, developed new mental health legislation, the Mental Healthcare Act, 2017, which received the assent of the president on 7 April 2017 and was commenced on 29 May 2018. The new legislation explicitly aims to comply with the CRPD and is thus a pioneering and exceptionally interesting development.

1.2. The Mental Healthcare Act, 2017

The evolution of India’s Mental Healthcare Act, 2017 was accompanied by considerable discussion about the emerging legislation (Suresh, 2014). There was praise for the focus on human rights but concerns about the feasibility, cost and possible implications of post-admission reviews (Kala & Kala, 2015; Rao et al., 2016; Sachan, 2013); changes to the role of families (Kala & Kala, 2015; Rao et al., 2016); changes concerning electro-convulsive therapy (ECT) (Narayan & Shekhar, 2015; Rao et al., 2016); revised licensing requirements, especially for general hospital psychiatric units (Gupta & Basu, 2016; Narayan & Shekhar, 2015); and potential creation of administrative and legal barriers to care (Antony, 2016).

Internationally, it was the human rights protections that attracted most attention (Kelly, 2016a; Sachan, 2013). The Act’s preamble is clear that these are the legislation’s central focus, stating that it aims ‘to provide for mental healthcare and services for persons with mental illness and to protect, promote and fulfil the rights of such persons during delivery of mental healthcare and services and for matters connected therewith or incidental thereto’. The legislation seeks explicitly to comply with the CRPD, noting that ‘it is necessary to align and harmonise the existing laws with’ the convention.

The CRPD established the Committee on the Rights of Persons with Disabilities to monitor implementation of the Convention (Article 34). General Comment No. 1 addresses Article 12, concerning ‘Equal recognition before the law’ (Committee on the Rights of Persons with Disabilities, 2014). The most contentious section concerns how this right pertains to Articles 15 (‘Freedom from torture or cruel, inhuman or degrading treatment or punishment’), 16 (‘Freedom from exploitation, violence and abuse’) and 17 (‘Protecting the integrity of the person’). The Committee states that countries ‘must abolish policies and legislative provisions that allow or perpetrate forced treatment’ (Paragraph 42). This has caused significant controversy in relation to mental

health law (Freeman et al., 2015; Scholten & Gather, 2018) and its implications must be considered when evaluating the India’s concordance with the CRPD.

2. Material and methods

This paper presents a systematic description of the content of India’s Mental Healthcare Act, 2017 based on a close reading of the legislation; discussion and analysis of key issues raised for India; and a distillation of central themes and innovations of relevance to other jurisdictions that seek to revise mental health legislation so as to increase compliance with the CRPD. To optimize coherence and integration within the paper, both the description of the legislation and analysis are presented together in the Results section under selected thematic headings, while key points are summarised and briefly discussed further in the Discussion and Conclusion.

3. Results

3.1. Definitions

India’s Mental Healthcare Act, 2017 defines ‘mental illness’ as ‘a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by subnormality of intelligence’ (Section 2(1)(s)).

This definition differs from that in England and Wales’s Mental Health Act 1983 (as amended by the Mental Health Act 2007), which states that ‘mental disorder’ is ‘any disorder or disability of the mind’ although ‘a person with learning disability shall not be considered by reason of that disability to be suffering from mental disorder [for specific purposes under the Act] unless that disability is associated with abnormally aggressive or seriously irresponsible conduct on his part’ (Section 1).

While the Indian definition of mental illness would appear to include personality disorder no explicit mention is made of it in the Act. The Inclusion of ‘conditions associated with the abuse of alcohol and drugs’ is very broad and could be applied to people engaging in harmful use (not just dependence). Unlike India, the definition in England and Wales excludes ‘dependence on alcohol or drugs’ but, like India, includes personality disorder. This contrasts with other countries such as Ireland which exclude both substance misuse problems and personality disorder for purposes of involuntary care. (Mental Health Act 2001, Section 8(2)). This may reflect the fact that the Indian Act has adopted a broader goal, of mental healthcare provision, rather than primarily providing a legal framework for involuntary treatment.

Unusually, the Indian legislation adds further provisions relating to the process of diagnosis, stating 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’ (Section 3(1)). In addition:

- ‘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’ in relevant legislation (Section 3(2));
- The ‘mental illness of a person shall not be determined on the basis of (a) political, economic or social status or membership of a cultural, racial or religious group, or for any other reason not directly relevant to mental health status of the person; (b) non-conformity with moral, social, cultural, work or political values or religious beliefs prevailing in a person’s community’ (Section 3(3));

- ‘Past treatment or hospitalisation in a mental health establishment though relevant, shall not by itself justify any present or future determination of the person’s mental illness’ (Section 3(4)); and
- ‘The determination of a person’s mental illness shall alone not imply or be taken to mean that the person is of unsound mind unless he has been declared as such by a competent court’ (Section 3(5)).

These provisions appear focused on ensuring high quality diagnostic processes and go into considerably more detail than legislation elsewhere in pursuing this goal. Diagnosis is also incorporated into the new Indian definition of ‘mental healthcare’, which ‘includes analysis and diagnosis of a person’s mental condition and treatment as well as care and rehabilitation of such person’ (Section 2(1)(o)). This reflects the reality that diagnosis is sometimes a protracted process and treatment can commence before the diagnostic process is complete; e.g. urgent treatment of acute psychosis before it is attributed to any specific mental illness.

A ‘mental health establishment’ is ‘any health establishment, including Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy establishment, by whatever name called, either wholly or partly, meant for the care of persons with mental illness’ where ‘persons with mental illness are admitted and reside at, or kept in, for care, treatment, convalescence and rehabilitation’, including ‘any general hospital or general nursing home’ but not family homes (Section 2(1)(p)). This broad definition reflects the diversity of approaches to mental health problems in India (Thirthalli et al., 2016). The definition of ‘mental health professional’ is similarly broad (Section 2(1)(r)).

3.2. Capacity

The Indian Mental Healthcare Act refers to the ‘capacity to make mental healthcare and treatment decisions’ (Section 4) rather than the broader concept of ‘mental capacity’. The validity and appropriateness of this latter term has been questioned (Committee on the Rights of Persons with Disabilities, 2014).

The Act affirms that ‘every person, including a person with mental illness shall be deemed to have capacity to make decisions regarding his mental healthcare or treatment if such person has ability to (a) understand the information that is relevant to take a decision on the treatment or admission or personal assistance; or (b) appreciate any reasonably foreseeable consequence of a decision or lack of decision on the treatment or admission or personal assistance; or (c) communicate the decision under sub-clause (a) by means of speech, expression, gesture or any other means’ (Section 4(1)). The word ‘or’, which appears after the first two components of this definition of mental capacity, is a typographical error and should read ‘and’; this error is currently being corrected under the Act’s ‘power to remove difficulties’ (Section 125(1)).

The Indian approach to defining capacity differs significantly from that in England and Wales where the Mental Capacity Act 2005 defines *lack of capacity*, stating that ‘a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain’ (Section 2(1)). ‘A person is unable to make a decision for himself if he is unable (a) to understand the information relevant to the decision, (b) to retain that information, (c) to use or weigh that information as part of the process of making the decision, or (d) to communicate his decision (whether by talking, using sign language or any other means)’ (Section 3(1)).

The Indian requirement to ‘appreciate any reasonably foreseeable consequence’ rather than being able to retain, use and weigh up information (as in England and Wales) arguably reflects a more consequentialist approach to defining capacity in India. This might also relate to the Indian legislators’ decision to define ‘capacity’ rather than *lack of capacity*, a decision which might account for the failure to replace ‘or’ with ‘and’ in the definition. Other aspects of the Indian

capacity definition, such as the requirement for information to be accessible (Section 4(2)) and tolerance of apparently ‘inappropriate or wrong’ decisions (Section 4(3)), are generally consistent with legislation elsewhere.

While the Indian Act defines ‘capacity to make mental healthcare and treatment decisions’ (Section 4), it makes only one direct reference to an individual ceasing to have such capacity; this is to describe the point at which an advance directive comes into force (Section 5(3)). This appears to contravene the General Comment No.1 on the CRPD (Committee on the Rights of Persons with Disabilities, 2014) which states that ‘the point at which an advance directive enters into force (and ceases to have effect) should be decided by the person and included in the text of the directive; it should not be based on an assessment that the person lacks mental capacity’ (Paragraph 17).

Indirect references to loss of capacity are made in the Indian Act in relation to supported treatments (Sections 86(3) and 89(1)(c)) and proxy consent (Sections 89(7) and 90(12)). However, it is unclear in the Act where the demarcation lies between a severe reduction in capacity being supported by a nominated representative on the one hand and a loss of capacity on the other. Failure to provide clear definitions in this area could lead to coercive treatments with limited review and appeal processes (Duffy & Kelly, 2017a).

The Committee on the Rights of Persons with Disabilities (2014) identifies the importance of separating the concepts of legal and mental capacity and is clear that ‘Article 12 does not permit ... denial of legal capacity, but, rather, requires that support be provided in the exercise of legal capacity’ (Paragraph 15). The Indian Mental Healthcare Act makes no mention of legal capacity, which is addressed in India’s Rights of Persons with Disabilities Act, 2016 (Section 13). Further guidance on capacity to be produced by an Expert Committee might address some of these issues (Section 81(1)).

3.3. Advance directives and nominated representatives

Under the 2017 Act, every adult ‘shall have a right to make an advance directive in writing’, specifying ‘the way the person wishes to be cared for and treated for a mental illness’; ‘the way the person wishes not to be cared for and treated’; and ‘the individual or individuals, in order of precedence’ they want to appoint as their ‘nominated representative’ (Section 5(1)). Critically, this can be done ‘irrespective of [the person’s] past mental illness or treatment for the same’ (Section 5(2)); this measure will hopefully help enhance respect for the autonomy of the mentally ill.

An advance directive is only invoked for the period during which a person lacks capacity (Section 5(3)); ‘may be revoked, amended or cancelled by the person who made it at any time’ (Section 8(1)); is ‘*ab initio* void’ if ‘contrary to any law’ (Section 5(5)); shall be kept in ‘an online register’ (Section 7); and does not apply to ‘emergency treatment’ (Section 9). Advance directives must be respected (Section 10) and those who do not wish to follow a patient’s advance directive must apply to a Mental Health Review Board for a review (Sections 11(1) and (2)).

‘The person writing the advance directive and his nominated representative’ must ensure treating practitioners have ‘access to the advance directive’ (Section 11(3)) and ‘a medical practitioner or a mental health professional shall not be held liable’ for (a) ‘any unforeseen consequences on following a valid advance directive’ (Section 13(1)) or (b) ‘not following a valid advance directive, if he has not been given a copy’ (Section 13(2)). These are sensible caveats that increase the operability of advance directives in practice and pre-emptively address the likely concerns of mental health professionals.

Overall, the provisions relating to ‘advance directives’ are among the most potentially useful but also controversial in the legislation. There was concern during their development that India was not ready for advance directives and that the evidence base supporting their use is weak (Rao et al., 2016). Notwithstanding these points, the Indian court

system has already taken notice of this Section of the 2017 Act: in 2018, the Supreme Court of India delivered a judgment concerning advance directives and noted that ‘Section 5 of the Mental Healthcare Act, 2017 recognises the validity of advance directives for the treatment of mental illness under the Mental Healthcare Act, 2017’ (Paragraph 132).¹

Advance directives will, also bring Indian legislation more in line with emerging developments elsewhere, such as in Ireland where the Assisted Decision-Making (Capacity) Act 2015 is introducing new, legally binding advance healthcare directives (Part 8) that are not unlike those in India. The role of advance directives in India, however, needs to be considered alongside the new and controversial roles for the patient’s ‘nominated representative’ under the 2017 Act.

Every adult ‘shall have a right to appoint a nominated representative’ (Section 14(1)) who must be a competent, consenting adult (Section 14(3)), nominated in writing (Section 14(2)). ‘Where no nominated representative is appointed’, the following persons, ‘in the order of precedence, shall be deemed to be the nominated representative of a person with mental illness, namely (a) the individual appointed as the nominated representative in the advance directive’; (b) ‘a relative’; (c) ‘a care-giver’; (d) ‘a suitable person appointed as such by the concerned [Mental Health Review] Board; or (e) if no such person is available to be appointed as a nominated representative, the Board shall appoint the Director, Department of Social Welfare, or his designated representative’ (Section 14(4)).

A person who has appointed a nominated representative ‘may revoke or alter such appointment at any time’ (Section 14(6)) and a Board may replace the representative ‘if it is of the opinion that it is in the interest of the person with mental illness to do so’ (Section 14(7)). ‘While fulfilling [their] duties under this Act, the nominated representative shall (a) consider the current and past wishes, the life history, values, cultural background and the best interests of the person’; (b) ‘give particular credence to the views of the person with mental illness to the extent that the person understands the nature of the decisions under consideration’; and (c) ‘provide support to the person with mental illness in making treatment decisions’, among other roles (Section 17).

The concept of the ‘nominated representative’ is an important one because the ‘nominated representative’ is likely to play many of the roles currently assumed by families (Singh, 2017). It is probable that many ‘nominated representatives’ will be family members but this is not necessarily the case (Duffy & Kelly, 2017a), leading to suggestions that the Act does not reflect the role of family in India and even undermines the fabric of Indian society as a result (Rao et al., 2016). Nonetheless, these measures give the individual receiving treatment a mechanism for preventing inappropriate coercion by their family.

3.4. Rights of persons with mental illness

In the international context, the Indian legislation’s rights provisions are possibly its most significant measures, especially in light of the CRPD (Sachan, 2013). The Act states that ‘every person shall have a right to access mental healthcare and treatment from mental health services run or funded by the appropriate Government’ (Section 18(1)); i.e. ‘services of affordable cost, of good quality, available in sufficient quantity, accessible geographically, without discrimination on the basis of gender, sex, sexual orientation, religion, culture, caste, social or political beliefs, class, disability or any other basis and provided in a manner that is acceptable to persons with mental illness and their families and care-givers’ (Section 18(2)).

The government ‘shall make sufficient provision as may be necessary’ (Section 18(3)), including ‘acute mental healthcare services’ (outpatient and inpatient); ‘half-way homes, sheltered accommodation,

supported accommodation’; ‘services to support family of person with mental illness or home based rehabilitation’; ‘hospital and community based rehabilitation establishments and services’; ‘child mental health services and old age mental health services’ (Section 18(4)).

The government shall ‘integrate mental health services into general healthcare services’; ‘provide treatment in a manner, which supports persons with mental illness to live in the community and with their families’; ensure that ‘long term care’ is ‘used only in exceptional circumstances, for as short a duration as possible, and only as a last resort when appropriate community based treatment’ has failed; ensure services are available locally insofar as possible; and pay for access elsewhere if needed (only for children and the elderly) (Section 18(5)).

‘Persons with mental illness living below the poverty line [or] who are destitute or homeless shall be entitled to mental health treatment and services free of any charge’ (Section 18(7)). All ‘medicines on the Essential Drug List shall be made available free of cost to all persons with mental illness at all times at health establishments run or funded’ by the government, as shall ‘essential medicines from any similar list relating to the appropriate ayurveda, yoga, unani, siddha, homoeopathy or naturopathy systems’ (Section 18(10)).

These rights provisions are greatly welcome and highly ambitious. They are clearly consistent with the CRPD and mark out the Indian legislation as both a pioneering reform in mental health law and an experiment to be watched with great care by other countries, especially those that have ratified the CRPD.

The concepts of rights to health and healthcare have histories that are long and complex (Rumbold et al., 2017; Tobin, 2012; Wolff, 2012), not least because while human rights protect important, fundamental needs, rights are not the same as needs (Osiatyński, 2009). Indeed, the vast majority of human needs are not claimed as rights but fulfilled through a range of other mechanisms such as political (rather than judicial) allocation of public resources, various commercial exchange mechanisms, family-sharing, community projects, charity, etc.

There is, however, a clear role for law when these mechanisms fail, such as when many people fail to receive the mental healthcare that they need. But even in this situation, it is not entirely clear if legally binding rights are the most effective, efficient and fair way of resolving matters, especially since the benefit of certain rights (e.g. a right to mental healthcare) depends on the degree to which other rights are fulfilled (e.g. the right to access an efficient court system). In addition, an increasingly legalized approach to these matters has been criticized as representing a fundamentally western approach that is potentially inappropriate to mental healthcare in India (Rao et al., 2016).

Notwithstanding these concerns, the new Indian legislation articulates not only rights to mental healthcare but also broader social rights for the mentally ill: ‘every person with mental illness shall (a) have a right to live in, be part of and not be segregated from society; and (b) not continue to remain in a mental health establishment merely because he does not have a family or is not accepted by his family or is homeless or due to absence of community based facilities’ (Section 19(1)). ‘Where it is not possible for a mentally ill person to live with his family or relatives, or where a mentally ill person has been abandoned by his family or relatives, the appropriate Government shall provide support as appropriate including legal aid and to facilitate exercising his right to family home and living in the family home’ (Section 19(2)) and access to ‘half-way homes, group homes and the like’ (Section 19(3)).

‘Every person with mental illness shall have a right to live with dignity’ (Section 20(1)); ‘be protected from cruel, inhuman or degrading treatment in any mental health establishment’ and shall have rights to (a) ‘live in safe and hygienic environment’; (b) ‘adequate sanitary conditions’; (c) ‘reasonable facilities for leisure, recreation, education and religious practices’; (d) ‘privacy’; (e) ‘proper clothing’; (f) ‘not be forced to undertake work in a mental health establishment and to receive appropriate remuneration for work’; (g) ‘adequate provision for preparing for living in the community’; (h) ‘adequate provision for wholesome food, sanitation, space and access to articles of personal

¹ *Common Cause (A Regd. Society) v. Union of India and Another* (2018) Supreme Court of India, Writ Petition (Civil) No. 215 of 2005.

hygiene, in particular, women's personal hygiene'; (i) 'not be subject to compulsory tonsuring (shaving of head hair)'; (j) 'wear own personal clothes' and 'not be forced to wear uniforms'; and (k) 'be protected from all forms of physical, verbal, emotional and sexual abuse' (Section 20(2)).

There are also specific rights according mental healthcare parity with physical healthcare (Section 21(1)); ensuring the welfare of children when their mother is mentally ill (Section 21(2)); promoting medical insurance for mental illness (Section 21(4)); ensuring access to information and reviews (Section 22(1)); confidentiality (Sections 23 and 24); access to medical records (Section 25); various matters relating to inpatient care (Section 26); to free 'legal aid' (Section 27); and to 'make complaints about deficiencies' in services (Section 28). These are very extensive rights provisions which would present substantial challenges to any country and will undoubtedly present challenges in India.

3.5. Roles of government, mental health authorities, and registration procedures

The 2017 Act accords extensive duties to government 'to plan, design and implement programmes for the promotion of mental health and prevention of mental illness' (Section 29(1)) and 'public health programmes to reduce suicides and attempted suicides' (Section 29(2)). The government has responsibilities in relation to human resources, education, training (Section 31) and co-ordination of services (Section 32), and 'shall make efforts to meet internationally accepted guidelines for number of mental health professionals on the basis of population, within ten years from the commencement of this Act' (Section 31(3)). This is a much-needed measure given current under-resourcing of mental health services in India (Jiloha, 2015; Patel et al., 2016; Singh, 2017).

The Central Government shall establish a 'Central Mental Health Authority' (Section 33) with membership to include various public officials and health professionals as well as 'two persons representing persons who have or have had mental illness', 'two persons representing care-givers of persons with mental illness', and 'two persons representing non-governmental organisations which provide services to persons with mental illness' (Section 34(1)). The Authority's functions relate to registration, standard-setting, supervision, training and advising government, among other roles (Section 43(1)).

In addition, each State Government shall establish a 'State Mental Health Authority' (Section 45) with membership including various public officials and health professionals (including 'one eminent psychiatrist') as well as 'two persons representing persons who have or have had mental illness', 'two persons representing care-givers of persons with mental illness' and 'two persons representing non-governmental organisations which provide services to persons with mental illness' (Section 46(1)). The functions of the State Mental Health Authority are similar to those of the Central Mental Health Authority, but at State level (Section 55(1)).

The Act requires that all mental health establishments are registered (Section 65). There is a detailed 'procedure for registration, inspection and inquiry' (Section 66) and the relevant 'Authority shall cause to be conducted an audit of all registered mental health establishments by such person or persons (including representatives of the local community) as may be prescribed, every three years' (Section 67(1)). The Authority can act upon complaints received (Sections 68 and 69). The key challenges with these authorities will undoubtedly lie in securing appropriate financial and human resources for them to operate effectively.

3.6. Mental health review boards

The system of post-admission reviews outlined in the 2017 Act is one of its key features (Duffy & Kelly, 2017a; Sachan, 2013). The Act states that 'the State Authority shall, by notification, constitute Boards

to be called the Mental Health Review Boards' (Section 73(1)) with each Board comprising (a) 'a District Judge, or an officer of the State judicial services who is qualified to be appointed as District Judge or a retired District Judge' (who shall chair the Board); (b) a 'representative of the District Collector or District Magistrate or Deputy Commissioner'; (c) 'two members of whom one shall be a psychiatrist and the other shall be a medical practitioner'; and (d) 'two members who shall be persons with mental illness or care-givers or persons representing organisations of persons with mental illness or care-givers or non-governmental organisations working in the field' (Section 74(1)). A quorum is three members (Section 76(2)) and decisions will be made by consensus, majority vote, or 'casting vote' (Section 76(1)).

'Any person with mental illness or his nominated representative or a representative of a registered non-governmental organisation, with the consent of such a person, being aggrieved by the decision of any of the mental health establishment or whose rights under this Act have been violated, may make an application to the Board seeking redressal or appropriate relief' (Section 77(1)).

'The Board, on receipt of an application' relating to 'admission of person with mental illness as independent patient in mental health establishment' (Section 85(1)), shall 'endeavour to hear and dispose of the same within a period of 90 days' (Section 80(1)). Applications 'for appointment of nominated representative' (Section 14(4)(d)), 'challenging admission of a minor' (Section 87), and 'challenging supported admission' (Sections 89(10) and (11)) shall be dealt with within seven days (Section 80(2)). 'The Board shall dispose of an application challenging supported admission under Section 90 [supported admission beyond 30 days]' within a period of 21 days' (Section 80(3)) and all other applications within 90 days (Section 80(4)).

'The proceeding of the Board shall be held *in camera*' (Section 80(5)) and, 'in respect of any application concerning a person with mental illness, [at] the mental health establishment' (Section 80(8)). 'The powers and functions of the Board shall, include all or any of the following':

- (a) 'To register, review, alter, modify or cancel an advance directive';
- (b) 'To appoint a nominated representative';
- (c) 'To receive and decide application from a person with mental illness or his nominated representative or any other interested person against the decision of medical officer or mental health professional in charge of mental health establishment' under Sections 87 ('admission of minor'), 89 ('supported admission') or 90 ('supported admission beyond 30 days');
- (d) 'To receive and decide applications in respect non-disclosure of information';
- (e) 'To adjudicate complaints regarding deficiencies in care and services'; and
- (f) 'To visit and inspect prison or jails and seek clarifications from the medical officer in-charge of health services in such prison or jail' (Section 82(1)).

This model of post-admission review, although clearly very important, fulfils some but not all of the human rights standards outlined by the WHO (2005) for independent reviews; e.g. it does not include long-term 'voluntary' patients (Duffy & Kelly, 2017a). It has been criticized as creating barriers to care delivery and potential delays owing to resource challenges (Rao et al., 2016), as well as placing mental healthcare decisions in the hands of non-experts (Narayan & Shekhar, 2015). Rao et al. (2016) suggest consumer-friendly independent hospital review boards as a more workable, less legalistic alternative, or the creation of a board of visitors at each hospital.

3.7. Admission, treatment and discharge

The 2017 Act outlines four admission statuses: 'independent admission' (voluntary admission), 'admission of minor', 'supported

admission' (admission and treatment without patient consent) and 'supported admission beyond 30 days'.

3.7.1. 'Independent admission' (voluntary admission)

'Independent admission' refers 'to the admission of [a] person with mental illness, to a mental health establishment, who has the capacity to make mental healthcare and treatment decisions or requires minimal support in making decisions' (Section 85(1)). 'All admissions in the mental health establishment shall, as far as possible, be independent admissions except when such conditions exist as make supported admission unavoidable' (Section 85(2)).

'Independent admission' occurs at the person's request (Section 86(1)) once 'the medical officer or mental health professional in charge of the establishment [...] is satisfied that (a) the person has a mental illness of a severity requiring admission'; (b) 'is likely to benefit from admission and treatment'; and (c) 'has understood the nature and purpose of admission'; 'has made the request for admission of his own free will, without any duress or undue influence'; and possesses mental capacity (Section 86(2)).

An 'independent patient' 'shall be bound to abide by order and instructions or bye-laws of the mental health establishment' (Section 86(4)) but 'shall not be given treatment without his informed consent' (Section 86(5)). Discharge must occur 'immediately on request made by such person or if the person disagrees with his admission' (Section 88(1)) unless 'the mental health professional is of the opinion that':

- (a) 'Such person is unable to understand the nature and purpose of his decisions and requires substantial or very high support from his nominated representative'; or
- (b) 'Has recently threatened or attempted or is threatening or attempting to cause bodily harm to himself'; or
- (c) 'Has recently behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him'; or
- (d) 'Has recently shown or is showing an inability to care for himself to a degree that places the individual at risk of harm to himself' (Section 88(3)).

Under these circumstances, 'a mental health professional may prevent discharge of [an independent patient] for a period of 24 hours so as to allow his assessment necessary' for 'supported admission' (Section 88(3)). The person shall then 'be either admitted as a supported patient' or discharged within 24 h (Section 88(4)). These measures are similar to those pertaining in many other jurisdictions for voluntary admission and treatment.

3.7.2. 'Admission of a minor'

For the admission of a minor (not yet 18 years of age) (Section 2(1)(t)), 'the nominated representative of the minor shall apply to the medical officer in charge of a mental health establishment for admission' (Section 87(2)). Admission may occur 'if two psychiatrists, or one psychiatrist and one mental health professional or one psychiatrist and one medical practitioner, have independently examined the minor on the day of admission or in the preceding seven days' and both conclude that the minor requires admission, admission is in the minor's best interest ('taking into account the wishes of the minor if ascertainable'), and there is no alternative, community treatment to meet the minor's needs (Section 87(3)).

'A minor so admitted shall be accommodated separately from adults, in an environment that takes into account his age and developmental needs' (Section 87(4)). 'The nominated representative or an attendant appointed by the nominated representative shall under all circumstances stay with the minor in the mental health establishment for the entire duration of the admission' (Section 87(5)). 'A minor shall be given treatment with the informed consent of his nominated representative' (Section 87(7)) and 'if the nominated representative no

longer supports admission' or requests discharge, 'the minor shall be discharged' (Section 87(8)). Admissions of minors are to be notified to the Mental Health Review Board within 72 h (Section 87(9)) and, if continued beyond 30 days, reviewed by the Board (Section 87(12)). The key issues here are likely limitations on the availability of suitable admission units, mental healthcare staff, and resources for post-admission reviews.

3.7.3. 'Supported admission' (admission and treatment without patient consent)

A person 'shall' be admitted as a 'supported admission' 'upon application by the nominated representative of the person' if:

- (a) 'The person has been independently examined on the day of admission or in the preceding seven days, by one psychiatrist and the other being a mental health professional or a medical practitioner, and both independently conclude based on the examination and, if appropriate, on information provided by others, that the person has a mental illness of such severity that the person (i) has recently threatened or attempted or is threatening or attempting to cause bodily harm to himself; or (ii) has recently behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him; or (iii) has recently shown or is showing an inability to care for himself to a degree that places the individual at risk of harm to himself';
- (b) 'The psychiatrist or the mental health professionals or the medical practitioner, as the case may be, certify, after taking into account an advance directive, if any, that admission to the mental health establishment is the least restrictive care option possible in the circumstances'; and
- (c) 'The person is ineligible to receive care and treatment as an independent patient because the person is unable to make mental healthcare and treatment decisions independently and needs very high support from his nominated representative in making decisions' (Section 89(1)).

The initial 'supported admission' must end when the person no longer meets these criteria (Sections 89(3) and 89(13)) or after 30 days (Section 89(2)). At this point, the person is discharged; the person can remain as an 'independent patient' (Section 89(5)); or the 'supported admission' can continue (Section 89(4)) under certain circumstances (Section 90).

The 'supported' patient 'shall be provided treatment after taking into account (a) an advance directive if any; or (b) informed consent of the patient with the support of his nominated representative' (Section 89(6)). If the person 'requires nearly 100% support from his nominated representative in making a decision in respect of his treatment, the nominated representative may temporarily consent to the treatment plan of such person on his behalf' (Section 89(7)). The medical officer must 'review the capacity of the patient to give consent every seven days' (Section 89(8)).

'Supported admissions' must be notified to the Mental Health Review Board within three days (for 'a woman or a minor') or seven days (others) (Section 89(9)). 'A person admitted under this section or his nominated representative or a representative of a registered non-governmental organisation with the consent of the person, may apply to the concerned Board for review of the decision' to admit the person (Section 89(10)). The Board will perform binding review within seven days (Section 89(11)).

This 'supported admission' status corresponds to 'involuntary admission' in other jurisdictions given that admission and treatment can occur without the consent of the patient. This status differs from involuntary admission in many other jurisdictions by apparently requiring the consent of the nominated representative in the absence of patient consent, rather than leaving final treatment decisions in the hands of medical professionals when patients lack mental capacity. It is

noteworthy that the ‘supported admission’ criteria in the Indian legislation do not include likelihood of deterioration without admission or a requirement for therapeutic benefit with admission, as suggested by the WHO (Duffy & Kelly, 2017a).

3.7.4. ‘Supported admission beyond 30 days’

If a ‘supported’ patient ‘requires continuous admission and treatment beyond 30 days’ (or readmission within seven days of discharge) (Section 90(1)), ‘the medical officer or mental health professional in charge of a mental health establishment, upon application by the nominated representative of a person with mental illness, shall continue admission of such person’ if relevant criteria are still ‘consistently’ fulfilled, following independent examinations by two psychiatrists (Section 90(2)). The medical officer must ‘review on the expiry of every fortnight, the capacity of such person to give consent’ (Section 90(13)).

Such admissions must be reported to the Mental Health Review Board within seven days (Section 90(3)) and ‘the Board shall, within a period of 21 days from the date of last admission or readmission [...] permit such admission or readmission or order discharge of such person’ (Section 90(4)), bearing in mind ‘(a) the need for institutional care to such person’ and ‘(b) whether such care cannot be provided in less restrictive settings based in the community’ (Section 90(5)).

‘The Board may require the medical officer or psychiatrist in charge of treatment of such person with mental illness to submit a plan for community based treatment and the progress made, or likely to be made, towards realising this plan’ (Section 90(6)). The ‘non-existence of community based services’ locally cannot justify such an admission (Section 90(7)), which is, in the first instance, limited to 90 days (Section 90(8)) but can be extended for 120 days and periods of 180 days thereafter, if criteria are met (Section 90(9)). These provisions for extending a ‘supported admission’ place welcome emphasis on active consideration of community-based alternatives.

The patient ‘or his nominated representative or a representative of a registered non-governmental organisation with the consent of the person, may apply to the concerned Board for review of the decision of the medical officer or mental health professional in charge of medical health establishment to admit such person in such establishment and the decision of the Board thereon shall be binding on all parties’ (Section 90(14)).

This ‘supported admission’ approach appears to be more concordant with General Comment No. 1 (Committee on the Rights of Persons with Disabilities, 2014) which states that the ‘human rights-based model of disability implies a shift from the substitute decision-making paradigm to one that is based on supported decision making’ (Paragraph 3). However, the Indian Act deviates from the CRPD in permitting proxy consent in circumstances where the individual receiving treatment ‘requires nearly hundred per cent support from his nominated representative in making a decision in respect of his treatment’ (Sections 89(7) and 90(12)). This proxy consent is, however, a temporary arrangement subject to review, weekly in the case of individuals in the first 30 days of a supported admission (Section 89(8)) and fortnightly thereafter (Section 90(13)).

3.7.5. Treatment

‘Emergency treatment’ ‘may be provided by any registered medical practitioner to a person with mental illness either at a health establishment or in the community, subject to the informed consent of the nominated representative, where the nominated representative is available, and where it is immediately necessary to prevent (a) death or irreversible harm to the health of the person; or (b) the person inflicting serious harm to himself or to others; or (c) the person causing serious damage to property belonging to himself or to others where such behaviour is believed to flow directly from the person’s mental illness’ (Section 94(1)). This ‘includes transportation of the person with mental illness to a nearest mental health establishment for assessment’ (Section 94(1)) but not ECT (Section 94(3)). There is a 72-hour time-limit,

increasing to seven days ‘during a disaster or emergency’ (Section 94(4)).

‘The following treatments shall not be performed’: ‘(a) ECT without the use of muscle relaxants and anaesthesia; (b) ECT for minors; (c) sterilisation of men or women, when such sterilisation is intended as a treatment for mental illness; (d) chained in any manner or form whatsoever’ (Section 95(1)). However, ‘if, in the opinion of psychiatrist in charge of a minor’s treatment, ECT is required, then, such treatment shall be done with the informed consent of the guardian and prior permission of the concerned Board’ (Section 95(2)).

The ban on unmodified ECT (i.e. without muscle relaxants and anaesthesia) has been criticized on the grounds that many Indian psychiatric hospitals do not have access to anaesthetists and that it is inappropriate to ban any treatment in mental health legislation (Narayan & Shekhar, 2015). Retention of unmodified ECT is supported by the Indian Psychiatric Society, the Indian Association of Biological Psychiatry, and the Indian Association of Private Psychiatry, who support the position that, under exceptional circumstances, if there is a strong indication for ECT and seizure modification with succinylcholine is not feasible, unmodified ECT, especially benzodiazepine-modified ECT, may be a viable option (Andrade et al., 2012). The ban, however, is supported by a broad range of user groups, care-giver groups and non-governmental advocacy organisations and by international authorities such as the WHO.

Under the new legislation, psychosurgery shall require informed consent from the patient and approval from the Mental Health Review Board (Section 96(1)). A patient ‘shall not be subjected to seclusion or solitary confinement, and, where necessary, physical restraint may only be used when (a) it is the only means available to prevent imminent and immediate harm to person concerned or to others; (b) it is authorised by the psychiatrist’ (Section 97(1)). ‘Physical restraint shall not be used for a period longer than it is absolutely necessary to prevent the immediate risk of significant harm’ (Section 97(2)); must be recorded and justified (Section 97(3)); ‘shall not be used as a form of punishment or deterrent’ or ‘on the ground of shortage of staff’ (Section 97(4)); and must be notified to the Board (Sections 97(7) and 97(9)) and the patient’s nominated representative (Section 97(5)).

Researchers ‘shall obtain free and informed consent from all persons with mental illness for participation in any research involving interviewing the person or psychological, physical, chemical or medicinal interventions’ (Section 99(1)). If the person ‘is unable to give free and informed consent but does not resist participation’, permission ‘shall be obtained from concerned State Authority’ (Section 99(2)). The State Authority may allow research ‘based on informed consent being obtained from the nominated representative’ only if specific conditions are met (Section 99(3)). Consent to research may be withdrawn at any time (Section 99(5)) and the Act does ‘not restrict research based study of the case notes of a person who is unable to give informed consent, so long as the anonymity of the persons is secured’ (Section 99(4)). Rao et al. (2016) suggest that too many regulations governing research might undermine further work.

3.8. Other provisions

The 2017 Act outlines provisions relating to police officers (Section 100), magistrates (Sections 101–102), prisoners (Section 103) and custodial institutions (Section 104).

One of the final key features of the legislation is the de facto decriminalization of suicide. The Indian Penal Code states that ‘whoever attempts to commit suicide and does any act towards the commission of such offence, shall be punished with simple imprisonment for a term which may extend to one year or with fine, or with both’ (Section 309). The 2017 Act states that ‘notwithstanding anything contained in Section 309 of the Indian Penal Code any person who attempts to commit suicide shall be presumed, unless proved otherwise, to have severe stress and shall not be tried and punished under the said Code’

(Section 115(1)). ‘The appropriate Government shall have a duty to provide care, treatment and rehabilitation to a person, having severe stress and who attempted to commit suicide, to reduce the risk of recurrence of attempt to commit suicide’ (Section 115(2)).

Finally, the Act defines ‘offences and penalties’ for specific infringements (Chapter XV) and the Mental Health Act, 1987 is repealed, subject to transitional arrangements (Section 126).

4. Discussion

The outstanding feature of India's Mental Healthcare Act, 2017 is that it seeks explicitly to comply with the CRPD and grants a legally binding right to mental healthcare to over 1.3 billion people. The legislation accords with many but not all of the specific human rights standards previously outlined by the WHO (2005); key areas of low concordance include the rights of families and carers, competence and guardianship, non-protesting patients and involuntary community treatment, which are not addressed adequately in the legislation (Duffy & Kelly, 2017a).

The Indian Act is one of the first in the world to make a concerted and explicit effort to adhere to the CRPD and it generally succeeds in this endeavour. However, General Comment No.1 (Committee on the Rights of Persons with Disabilities, 2014) appears to set a higher standard than the CRPD itself and in this respect the Indian Mental Healthcare Act might fall short. Clearly, legislators need to negotiate carefully the areas of capacity and demarcation between supported and proxy decisions if they are to accord with the General Comment. Careful consideration of unintended consequences will be paramount as there is a high risk that an overly rigid interpretation of the General Comment No.1 would undermine important human rights (Duffy & Kelly, 2017c; Freeman et al., 2015; Scholten & Gather, 2018).

On the other hand, the 2017 Act has the important strength of articulating not only extensive rights to mental healthcare but also social rights for the mentally ill as well as rights in many other areas that are often neglected, such as confidentiality (Duffy & Kelly, 2017b; Kelly, 2017). While there has been much discussion in the literature about the application of rights-based approaches in psychiatry (Javed & Amering, 2016), with particular concern about possible excessive legalism (Rao et al., 2016), the Act's clear articulation of rights can be a very positive step once it is implemented in a progressive, realistic and sustainable fashion, taking account of local resources, traditions and structures. The focus on rights is further emphasised by the Rights of Persons with Disabilities Act, 2016, another piece of legislation written to bring Indian legislation in line with the CRPD. This Act legislates for multiple social and economic rights for individuals with disabilities, including those with mental illness.

Other key measures in the 2017 legislation include:

- New definitions of ‘mental illness’ (which includes both personality disorder and addiction problems but places particular emphasis on the diagnostic process), ‘mental health establishment’ (to include a broad range of facilities, reflecting the diversity of approaches to mental illness in India) (Thirthalli et al., 2016), and ‘capacity’;
- ‘Advance directives’ to permit persons with mental illness to direct future care as is increasingly the case in other jurisdictions, although concerns have been expressed that India might not yet be ready for this measure and that the evidence-base for advance directives is weak (Rao et al., 2016);
- Creating ‘nominated representatives’, who need not be family members but most likely will be; it is unusual in the international context that the ‘nominated representative’ will have the power to consent to treatment if the patient lacks capacity, although this might help address concerns that the legislation disempowers families (Narayan & Shekhar, 2015; Rao et al., 2016);
- Post-admission reviews by Mental Health Review Boards, although the effectiveness of these are reliant on adequate financial and

human resources so that they function in an effective, timely manner; there is concern that these may place healthcare decisions in the hands of non-experts (Narayan & Shekhar, 2015) and that independent hospital review boards would be more workable (Rao et al., 2016);

- Revised procedures for ‘independent admission’ (voluntary admission), ‘supported admission’ (admission and treatment without patient consent), and ‘admission of a minor’; these procedures meet some but not all of the relevant WHO standards; e.g. criteria for ‘supported admission’ do not include likelihood of deterioration without admission or requirement for therapeutic benefit with admission (Duffy & Kelly, 2017a);
- Revised rules governing treatment, restraint and research; in particular, it is to be hoped that the research provisions facilitate research rather than delay or complicate it (Rao et al., 2016);
- De facto decriminalization of suicide, which brings India into line with international trends.

The greatest challenge presented by the new Indian legislation relates to resourcing of both mental health services and the new structures proposed in the Act. With India's mental health system generally under-resourced (Patel et al., 2016; Singh, 2017), doubts have been raised about the appropriateness of an increasingly legalized approach to care (especially the implications of potentially lengthy judicial proceedings) (Rao et al., 2016) and possible paradoxical effects resulting in barriers to care (e.g. revised licensing requirements for general hospital psychiatry units, which had previously been exempt from the same licensing standards) (Narayan & Shekhar, 2015).

There is particular ongoing controversy about specific measures including the legislation's ban on unmodified ECT (Section 3.7.5). As noted, this ban has been criticized on the basis that anaesthetists are not always available and that legislation should not be used to ban specific treatments (Narayan & Shekhar, 2013). The retention of unmodified ECT is supported by the Indian Psychiatric Society, the Indian Association of Biological Psychiatry, and the Indian Association of Private Psychiatry, who have agreed on recommendations governing its use; i.e. that, under exceptional circumstances, if there is a strong indication for ECT and seizure modification with succinylcholine is not feasible, unmodified ECT, especially benzodiazepine-modified ECT, may be a viable option (Andrade et al., 2012).

It must be borne in mind, however, that our analysis of the 2017 Act reflects predominantly the voice and views of the psychiatric profession, through our use of academic papers and similar sources. It is necessary to acknowledge that various non-professional stakeholders (e.g. mental health services users, advocacy non-governmental organisations, care-givers, etc.) often hold quite different views. For example, as already mentioned, the ban on unmodified ECT is supported by a range of user groups, care-giver groups and non-governmental advocacy organisations and the WHO. Some groups want all ECT banned and criticize the 2017 Act for legalizing modified ECT.

This is an important issue because almost half of administrations of ECT in India are unmodified (Firdosi & Ahmad, 2016). The need to resolve differences of opinion on this matter (e.g. through time-lined implementation and upgrading of services, with defined resource targets) reflects the need for continued and meaningful engagement by multiple stakeholders including patient groups, families and carers, Central and State governments, the Indian Psychiatric Society, other professional groups, and non-governmental organisations as implementation progresses.

In particular, it remains to be seen how the nominated representative's role will facilitate the treatment of individuals who need very high levels of support in making decisions. It is conceivable under that new Act potential coercion by mental health professionals will be reduced but potential coercion by nominated representatives could replace it. This might result in individuals with limited experience and potentially competing interests exercising high levels of influence over

vulnerable individuals, in the place of trained professionals regulated by accrediting bodies and held to professional standards (Duffy & Kelly, 2017a).

5. Conclusions

Despite various conceptual and (especially) practical challenges, India's new mental health legislation offers substantial potential benefits not only to India but also, by example, to other countries that seek to align their laws with the CRPD and improve the position of the mentally ill in their societies.

During implementation, the opportunities offered by rights-based approaches (Funk & Drew, 2017) need to be set against some of the limitations of rights-based mental health laws, including problems deciding which rights matter most in situations when rights conflict, as well as broader issues relating to the fundamental notion of rights-based legalism in mental health in the first place (Kelly, 2015, 2016b; McSherry & Weller, 2010). It would be deeply regrettable, for example, if the new Indian legislation, despite its focus on rights, and especially the right to mental healthcare, was to present obstacles to accessing appropriate services (Antony, 2016; Duffy, Narayan, Goyal, & Kelly, 2018), delays in care delivery, or barriers to research aimed at improving future services (Rao et al., 2016).

Much depends on the content and operation of the final draft of rules made under the legislation, the willingness of government to enhance resources to meet the standards outlined, and the extent to which the effects of the legislation, both positive and negative, are studied over the coming years. This issue of empirical evidence is an important one and outcome evaluations will hopefully emphasise a realization-focused understanding of justice, based on the real-life outcomes of measures intended to protect rights, rather than just an arrangement-focused view of justice, based on verifying that current legislation and other arrangements appear *likely* to promote human rights (Sen, 2009). Sometimes, the effects of legislation can be paradoxical and even negative, despite everyone's best intentions.

Most of all, it is important that India's experiment in granting a legally binding right to mental healthcare is progressed in a timely, collaborative and sustainable fashion so as to ensure it truly delivers benefit to those who need it; i.e. the mentally ill and their families and carers. It would be a matter of great regret if the 2017 Act ended up stranded in an indeterminate no-man's land between excellent intentions on the one hand and terminal difficulty with implementation on the other (Sharma, 2017). That could be an outcome worse than doing nothing at all.

The mentally ill deserve the highest levels of mental health and social care that are possible. The Mental Healthcare Act 2017 presents a unique opportunity to pursue both better care and greater social justice for the mentally ill in India, once implementation is informed by realism, rooted in genuine collaboration, and subject to ongoing evaluation and research over the coming years.

Declaration of interest

None.

Animal and human rights

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Stigma, inclusion and India's Mental Healthcare Act 2017

Richard M. Duffy, Gautam Gulati, Niket Kasar, Vasudeo Paralikar, Choudhary Laxmi Narayan, Avinash Desousa, Nishant Goyal and Brendan D. Kelly

Abstract

Purpose – India's Mental Healthcare Act 2017 provides a right to mental healthcare, revises admission and review procedures, effectively decriminalises suicide and has strong non-discrimination measures, among other provisions. The purpose of this paper is to examine Indian mental health professionals' views of these changes as they relate to stigma and inclusion of the mentally ill.

Design/methodology/approach – The authors held nine focus groups in three Indian states, involving 61 mental health professionals including 56 psychiatrists.

Findings – Several themes relating to stigma and inclusion emerged: stigma is ubiquitous and results in social exclusion; stigma might be increased rather than remedied by certain regulations in the 2017 Act; stigma is not adequately dealt with in the legislation; stigma might discourage people from making "advance directives"; and there is a crucial relationship between stigma and education.

Practical implications – Implementation of India's 2017 Act needs to be accompanied by adequate service resourcing and extensive education, including public education. This has commenced but needs substantial resources in order to fulfil the Act's potential.

Social implications – India's mental health legislation governs the mental healthcare of 1.3bn people, one sixth of the planet's population; seeking to use law to diminish stigma and enhance inclusion in such a large country sets a strong example for other nations.

Originality/value – This is the first study of stigma and inclusion since India's 2017 Act was commenced and it highlights both the potential and the challenges of such ambitious rights-based legislation.

Keywords Stigma, Inclusion, India, Human rights, Psychiatry, Mental health legislation

Paper type Research paper

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Introduction

People with mental disorders commonly experience loss of liberty, social exclusion, stigma and denial of human rights (Kelly, 2016). As a result, the role of legislation in relation to the mentally ill requires careful and ongoing attention to ensure that it facilitates treatment, maximises liberty, minimises suffering, and is equitable, proportionate and fair.

This issue came into new focus in 2006 following the United Nations' Convention on the Rights of Persons with Disabilities (CRPD) which aims "to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities", including "those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others" (United Nations, 2006). In 2017, the World Health Organisation emphasised the "vital role" of law in "advancing the right to health" (World Health Organisation, 2017), further underlining the need for countries to ensure that their mental health legislation is up-to-date, effective and focussed on human rights, including the right to treatment.

Against this background, the commencement of India's Mental Healthcare Act 2017 in May 2018 is a powerful, if complex, example of potentially positive change (Narayan and Shekhar, 2015; Kalmegh *et al.*, 2018; Mishra and Galhotra, 2018; Duffy and Kelly, 2017a, b, c, 2019a).

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India's 2017 Act is the first piece of mental health legislation in the world drafted explicitly to accord with the CRPD and it includes a right to mental healthcare, revised admission and review procedures, *de facto* decriminalisation of suicide, and strong non-discrimination measures, among other provisions. It follows on from India's similarly ambitious Rights of Persons with Disabilities Act 2016 which also sought to accord with the CRPD.

The right to mental health care is arguably the most ambitious element of the 2017 Act (Duffy and Kelly, 2019b). The legislation states that "every person shall have a right to access mental healthcare and treatment from mental health services run or funded by the appropriate Government" (Section 18(1)). The Government shall provide "acute mental healthcare services"; "half-way homes, sheltered accommodation, supported accommodation"; "services to support family of person with mental illness or home based rehabilitation"; "hospital and community based rehabilitation establishments and services"; "child mental health services and old age mental health services" (Section 18(4)).

Realising this right in practice would be an enormous undertaking for any country and mental health services in India are already substantially under-resourced (Gururaj *et al.*, 2016). As a result, articulating and pursuing this right offers a real and radical opportunity to promote the rights of the mentally ill in India, including the right to treatment, to enhance social inclusion and to decrease stigma, which is an extensive problem in India as it is elsewhere (Mahomed *et al.*, 2019). Against this background, psychiatrists in India have voiced certain concerns about particular elements of the legislation, especially its implementation, but they also express optimism (Duffy *et al.*, 2018). This paper presents an analysis of focus groups among mental health professionals, chiefly psychiatrists, in India looking at the themes of stigma and inclusion in the context of the new legislation, examining whether the 2017 Act is likely to assist with these issues as it is implemented.

Methods

Study setting, recruitment and participants

We held nine focus groups across Maharashtra, Bihar and Jharkhand, three states in India, in 2017 and 2018. In total, 61 mental health professionals participated in the groups, including 56 psychiatrists. We used a purposive sampling method to identify potential informants with high levels knowledge from a range of psychiatric settings: general hospital psychiatric units (GHPUs), stand-alone psychiatric hospitals and private psychiatric facilities (Barbour, 2007; Elo *et al.*, 2014). To recruit participants, we contacted key psychiatrists and academics in India who agreed to assemble focus groups using existing local continuing professional development networks. Each of these psychiatrists organised one to four groups each, ensuring that while each of the groups was individually relatively homogenous, each group represented a different area of practice in psychiatry. At locations where two focus groups were conducted, senior staff members were interviewed separately in order to minimise group heterogeneity and issues of power relations (Stalmeijer *et al.*, 2014).

Focus groups

Each focus group comprised six to ten participants and lasted between 45 and 90 min. We used a brief questionnaire to collect demographic and professional information about participants. Each focus group then set out to examine participants' views on India's Mental Healthcare Act 2017. Each group had one moderator who led the discussion and two observers who recorded who was speaking, documented key information, and addressed logistical and practical issues relating to the running of the group. The focus group questioning route (Krueger and Casey, 2015) evolved out of detailed document analysis and interviews with key stake holders prior to commencement of the study.

In terms of opening questions, focus groups explored participants' views regarding what they felt was positive about the new legislation, their concerns about it, what they felt needed to be done during the transitional phase, and what they would have done differently if they were writing the legislation. With these questions as focus points, the moderator encouraged participants to examine emergent topics that they found more relevant. The moderator and observer debriefed after each group in order to facilitate an iterative development of the questioning route.

Data analysis

Focus groups were recorded and the recordings transcribed. Data were coded inductively and a conventional content analysis was performed by two of our team independently and collaboratively in an iterative process (Charmaz, 2004; Hsieh and Shannon, 2005). We identified relevant categories within the data and incorporated related categories into higher order categories. We analysed data using NVIVO (Version 12.0). For the present analysis, themes and sub-themes relating to stigma and inclusion were analysed; other categories that emerged in relation to these themes were also included in this analysis. The paper was revised and edited by all co-authors.

Ethics

Research ethics approval was obtained prior to commencement and written informed consent was received from all participants prior to participation.

Results

We held nine focus groups (each with six to ten participants) at seven centres; three groups in December 2017, prior to commencement of the new legislation, and six in November 2018, after commencement, although key elements of the legislation had not yet been implemented in practice at that point (e.g. Mental Health Review Boards to review certain admissions had not been established). In total, 56 of the 61 participants were consultant psychiatrists; the others included hospital heads of occupational therapy, nursing, and social work, a senior mental health administrator and a consultant anesthetist who assisted in providing electro-convulsive therapy (ECT). Majorities of participants were male (77 per cent), working in general adult psychiatry (92 per cent) and public practice (73 per cent), with a mean of 14 years' experience. Minorities worked in private practice (40 per cent) and rural settings (20 per cent).

Several key themes relating to stigma and inclusion emerged from the focus groups: that stigma is ubiquitous in relation to psychiatry in India and results in social exclusion; stigma might be caused by certain regulations in the 2017 Act, including regulation of GHPUs and ECT; stigma is not adequately dealt with in the new legislation; stigma might discourage people from making "advance directives" under the 2017 Act (to direct future care); and there is a crucial relationship between stigma and education.

Stigma is ubiquitous in relation to psychiatry in India and results in social exclusion

Several focus group members commented that stigma was very common in India: "the need of the time is to destigmatise". Stigmatising portrayals of mental illness and the mentally ill in the media emerged as a particular theme, with participants commenting on portrayals "in a very wrongful manner by media" (especially cinema) and "discrimination of these people". ECT "has been very negatively portrayed by the media so there is a lot of stigma associated with ECT. That is why people are not very forthcoming; when you advise them 'ECT', they [want] to continue with the medication".

Participants were especially concerned about the adverse effects of stigma on community re-integration and expressed the view that the 2017 Act did not address this sufficiently. This was especially true in relation to "patients going back to community", according to one participant who was concerned with "not only rights; I mean their social acceptance; some measures, some mentions should be there [in the legislation]".

Stigma might be caused by certain regulations in the 2017 Act

The view emerged that sending patients to stand-alone psychiatric hospitals and other admission units regulated by the 2017 Act might increase stigma because people would fear being "sectioned" (admitted against their wishes) as a result of the very existence of such legal regulation. As the 2017 Act will regulate GHPUs, it was felt that the legislation would therefore increase stigma through regulation: "everyone is being sectioned" by applying the Act, according to one comment.

GHPUs were not similarly regulated under the 1987 legislation: they had no similar requirement for licencing and they commonly admitted individuals for the treatment of mental illness, according to participants. These units are viewed more positively by patients who feel they would be stigmatised by going to stand-alone psychiatric hospitals which generally treat individuals with chronic and enduring mental illness. Our participants raised the concern that the inclusion of GHPUs in the new licencing requirements would cause many GHPUs to close due to the administrative and resource burden. This would result, they felt, in fewer treatment options for individuals with mental illness and more treatment being provided in institutions that evolved out of old asylums. There was also a fear that families would not come “back to take the patient back because of the stigma”. If the Act was to be commenced without appropriate resourcing, it was felt that everything would become more legally tenuous and this would further damage psychiatry’s reputation in India.

There was also concern that the 2017 Act’s regulation of ECT (it closely regulates ECT in minors and bans “unmodified” ECT, without anaesthetic) would increase stigma simply by the fact of ECT being so closely regulated: “putting so many restrictions on giving ECT is I don’t think a good thing”. Other participants elaborated further:

By denying this treatment [unmodified ECT] it will also evoke more stigma in people about psychiatric treatment in general because many of the times people fear psychiatric treatment because of this anticipation. There is huge stigma.

People already fear psychiatric treatment and by putting this treatment [ECT] as a restrictive one through an Act, this will increase fear in general, about psychiatric treatment – a long-term implication of this Act.

Stigma is not adequately dealt with in the Mental Healthcare Act 2017

Despite the 2017 Act’s non-discrimination measures, focus group participants expressed the view that the legislation was “absolutely silent” about stigma even though “stigmatisation is a very important thing”. The new legislation could, they felt, increase rather than decrease stigma:

I think after this law psychiatrists are going to be more stigmatised and vulnerable in the eye of the society. Most of the society is not aware about this law.

Participants felt the Act should contain active measures to reduce stigma: “more should be there”. Instead, participants felt the legislation might increase stigma in various ways, chiefly related to perceived increases in regulation of GHPUs and ECT which patients and families would, they felt, find off-putting.

Stigma might discourage people from making “advance directives” under the 2017 act

Focus group participants felt that stigma was linked with implementation of advance directives, especially in the absence of appropriate “groundwork”:

The other aspect regarding advance directives is stigma. The Act does nothing to talk about the stigma or how we need in the present scenario to tackle the existing stigma in this society which is very much at present. Advance directives initially did start for the end-of-care patients. Subsequently it’s been moved on to mental health as well. Even when you look in the developed countries, it’s not uniformly acceptable and it has had its own problems with the implementation as well. So, implementing at this point of time without a good groundwork about how it will be effective might have its own challenges.

Participants felt that stigma might prevent people from making advance directives because people do not want to acknowledge that they may become ill again in the future and do not want to be seen as mentally ill by friends or family. Education and awareness might help address this:

There’s a lot of stigma. If you tell someone to make an advance directive, they will get offended: “are you saying that I will get a mental illness?” So that is the issue here; it is that kind of stigma that you can’t tell them to make an advance directive. So, without awareness, I don’t think that there is going to be a lot of change, especially to the illiterate class of people that we see.

Relationship between stigma and education

Lack of education was identified as a key driver of stigma in India, with significant impact on treatment:

Because they are not educated there's a lot of stigma attached regarding the treatments, a lot of negative beliefs about psychiatric medications causing a lot of side effects, and ECT, so that will all have an overall impact on the line of treatment.

Focus group participants expressed the view that time and resource constraints in psychiatry in India limit psycho-education which might otherwise help reduce stigma over time: "stigma, discrimination, these things will not go overnight". There was particular concern about the impact of stigma and a lack of psycho-education in advance of certain elements of the new Act, such as Mental Health Review Boards which will end up bearing significant responsibility for the reputation of the legislation and – by implication – psychiatry in India:

The perception about mental illnesses in this society is quite different. We are having Review Boards in which persons who will be there have no idea what mental illness is, what kind of treatment, what kind of things will be given to the mentally ill patients. First, society has to learn what is a mental illness and the stigma associated with this has to be removed before we can go to that stage. We need to improve certain things before we can reach that stage.

Discussion

It is already documented elsewhere that psychiatrists in India readily identify many positive aspects of the Mental Healthcare Act 2017, including enhanced protection of rights, promotion of autonomy and *de facto* decriminalisation of suicide (Duffy *et al.*, 2018). This focus group analysis, however, examined issues relating to stigma and inclusion, and identified several key themes of relevance connected with the new legislation: that stigma is ubiquitous and results in social exclusion, which is especially problematic in relation to community integration; stigma might be increased by certain regulations in the 2017 Act, rather than remedied by them; stigma is not adequately dealt with in the new legislation, despite its non-discrimination measures; stigma might discourage people from making "advance directives"; and there is a crucial relationship between stigma and education, especially public education about mental illness and its treatment.

Strengths and limitations of the present study

Our study focusses on India's new Mental Healthcare Act 2017, the first piece of mental health legislation to explicitly seek to accord with the CRPD and the most potentially impactful piece of mental health legislation in the world, owing to India's population of 1.3bn people, one sixth of the planet's population. We used validated focus group methodologies to gather data; we used robust analytic methods to interrogate our findings; and our research group includes both Indian and non-Indian psychiatrists.

The evolving implementation of the Indian legislation over our study period was a complicating factor in our work, as the Act was formally commenced mid-way through our project; it was not, however, implemented in practice in the places we visited, giving us access to Indian psychiatry during a unique transitional and anticipatory period.

While we reached theoretical saturation of our focus group data and identified significant thematic consistencies across groups, our sample was weighted towards academic, urban psychiatrists treating adults, so it remains possible that groups of differing compositions, at different times or in different locations would have yielded more or other data. On the other hand, strong, heterogenous opinions were acquired from both sides of various debates in our groups, supporting the validity of our findings.

Implementing the 2017 Act

Perhaps the greatest message from this analysis of our focus group data is that psychiatrists in India are acutely aware of the issue of stigma and present highly nuanced understandings of how

this might interact with implementation of the new legislation. On the face of it, the text of the 2017 Act contains many measures that should, in theory, decrease stigma: increased access to better care, decriminalisation of suicide, more uniform regulation of admission facilities, revised procedures for advance directives, explicit non-discrimination measures and various other provisions (Duffy and Kelly, 2019a).

Paradoxically, however, the mental health professionals in our focus groups were clear that implementation without adequate resourcing (Gururaj *et al.*, 2016) and without adequate public education was just as likely to increase stigma as to decrease it, and might well discourage people from engaging with some of the measures designed to improve services and ostensibly reduce stigma (regulating GHPUs and ECT, advance directives, etc.). Bringing more services under the remit of legislative regulation caused particular unease, and there was an especially clear defence of the current situation regarding GHPUs.

Most of all, however, focus groups participants felt that an understanding of the relationship between stigma and education could both help elucidate the roots of stigma (lack of knowledge) and point to a potential solution: education, especially public education, as the Act is being implemented and as increased community care places increased responsibility on communities. There is also a need to revise curriculums in medical schools and continuing professional development courses (which has already commenced) in order to keep clinical practice and the law in harmony, ensure that the new measures foster co-working rather than dissent between patients and psychiatrists, and ensure that the new law is not itself stigmatised owing to limited awareness or misunderstandings.

These are important issues. The Mental Healthcare Act 2017 is already having significant effects on the legal landscape in India. For example, the Supreme Court of India relied significantly on the strong anti-discriminatory provisions of the 2017 Act to conclude that homosexuality is not a mental illness and that LGBTIQ persons cannot be discriminated against on the basis of sexual orientation (Kapoor and Pathare, 2019). The Court's reading of the 2017 Act and Section 377 of the Indian Penal Code 1860 was significant because its rationale can be extended further to challenge various other laws which discriminate against persons with mental illness.

Conclusion

With the Mental Healthcare Act 2017, India has undertaken one of the world's largest experiments in rights-based healthcare and certainly the world's most ambitious and potentially impactful reform of mental health law in many decades. The 2017 Act offers a once-in-a-lifetime opportunity to address the stigma associated with mental illness, reduce discrimination and enhance social inclusion. Our focus groups felt, however, that there is a paradoxical but real risk of increasing stigma and excluding the mentally ill if implementation is not accompanied by additional resourcing and public education. Both are clearly vital if this ambitious project is to succeed.

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A Focus Group Study of Indian Psychiatrists' Views on Electroconvulsive Therapy under India's Mental Healthcare Act 2017: 'The Ground Reality is Different'

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ABSTRACT

Background: India's Mental Healthcare Act, 2017 (MHCA) greatly restricts the use of electroconvulsive therapy (ECT) in minors and bans unmodified ECT. Indian psychiatrists have raised concerns that these measures may deprive certain patients of life-saving treatment. This study describes the perspectives of Indian psychiatrists on how ECT is dealt with in the legislation. **Methods:** We conducted nine focus groups in three Indian states. We explored the positive and negative implications of the MHCA and discussed its implementation, especially in relation to ECT. **Results:** Many of the themes and concerns commonly discussed in relation to ECT in other jurisdictions are readily apparent among Indian psychiatrists, although perspectives on specific issues remain heterogeneous. The one area of near-universal agreement is Indian psychiatrists' affirmation of the effectiveness of ECT. We identified three main areas of current concern: the MHCA's ban on unmodified ECT, ECT in minors, and ECT in the acute phase. Two broad additional themes also emerged: resource limitations and the impact of nonmedical models of mental health. We identified a need for greater education about the MHCA among all stakeholders. **Conclusion:** Core concerns about ECT in India's new legislation relate, in part, to medical decisions apparently being taken out of the hands of psychiatrists and change being driven by theoretical perspectives that do not reflect "ground realities." Although the MHCA offers significant opportunities, failure to resource its ambitious changes will greatly limit the use of ECT in India.

Key words: *Electroconvulsive therapy, human rights, India, jurisprudence, mental health legislation*

Key Messages: *a) Indian psychiatrists have grave concerns about legislative restrictions on ECT and mental health resource limitations. b) There is a need for greater education about the Mental Healthcare Act, 2017 among all stakeholders, not least because failure to resource its ambitious changes will greatly limit ECT in India.*

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India has radically revised its mental health laws with the introduction of the Mental Healthcare Act, 2017 (MHCA). This legislation seeks to make India's mental health law concordant with the United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD) and, arguably, represents a paradigm shift toward rights-based, patient-centered mental health law.^[1-3] Both the CRPD and the MHCA have proved to be controversial, and many psychiatrists are significantly concerned about the unfolding legislative changes.^[4-7] One of the major areas of contention is electroconvulsive therapy (ECT).

The MHCA will impact the use of ECT in many ways. Involuntary admissions are being replaced by supported admissions (Sections 89--90), and while ECT can be given to supported patients, there are significant administrative and regulatory requirements. Section 95 of the new legislation bans unmodified ECT (i.e., ECT without anesthetic) and only permits ECT in minors with the consent of the guardian and Mental Health Review Board (MHRB). Section 94 bans ECT during emergency treatment outside of the hospital or in nonmental health establishments.

ECT is widely used in India. One survey of 66 hospitals identified almost 20,000 patients receiving over 110,000 sessions of ECT in a 1-year period, of whom more than half received unmodified ECT.^[8] Psychiatrists have expressed concern that restrictions on ECT in the MHCA will deprive certain patients of life-saving treatments.^[9,10] In contrast to the concerns of psychiatrists, many ethical issues have been raised about the practice of ECT in India and media portrayals have increased stigma.^[11,12]

This study aims to describe the perspectives of Indian psychiatrists on how ECT is dealt with in the MHCA. Using focus group methodology, common themes relating to ECT and the new legislation are identified, examined, and explored.

METHODS

A focus group methodology was employed to explore mental health professionals' perceptions of the MHCA in general, with the intention of focusing more closely on specific issues as they emerged. Focus group methodology was chosen because the topics being explored are complex and tend to elicit complex opinions, and additional insights were to be gained from both the emotional content expressed in focus groups and from interactions during focus group discussions. Many of these subtleties are not amenable to quantitative approaches. Ethical approval was

granted by Trinity College Dublin's School of Medicine Research Ethics Committee.

Population and sampling

Nine focus groups were conducted, in seven centers, in three states (one in Bihar, two in Jharkhand, six in Maharashtra) between November 2017 and November 2018. Sixty-one mental health professionals participated, including 56 psychiatrists. A purposive sampling method was adopted, and informants with high-level knowledge of the MHCA were sought from a wide range of backgrounds.^[13,14] Focus groups were organized by key academics through existing local professional development groups. At locations where two focus groups were conducted, senior staff who were longer in practice were included in focus groups separate from other staff in an attempt to minimize group heterogeneity.^[15] Groups were divided so that psychiatrists who had practiced for longer were interviewed in the same group, in order to reduce the effect of power dynamics within focus groups, as suggested by the Krueger and Casey.^[16] Focus groups were mixed by specialty and subspecialty because most psychiatrists had multiple specialties, and specialty or sub-specialty did not affect the power balance within groups.

Focus groups

Focus groups consisted of six to ten individuals and lasted between 45 and 90 min. Written informed consent was obtained from all participants. All focus groups had one moderator who led the discussion and one to two observers who recorded who was speaking and documented nonverbal information. The questioning route (see Appendix) evolved out of extensive document analysis and the relevant published literature.^[2,3,16-18]

Focus groups were audio-recorded and recordings transcribed. Nonverbal information was documented on paper by the observers during the focus groups and was coded when listening to the audio-recordings during the analysis phase of the study.

In terms of opening questions, focus groups explored participants' views regarding what they felt was positive about the new legislation, their concerns about the MHCA, what they felt needed to be done during the transitional phase, and what they would have done differently if they were writing the legislation themselves (see Appendix). With these questions as focus points, the moderator encouraged participants to examine emergent topics that they found especially relevant. The moderator and observer debriefed after each group in order to facilitate an iterative development of the questioning route as the study

progressed. Demographic and professional information was collected on all participants.

Data analysis

Focus groups were audio-recorded and recordings transcribed. Data were coded inductively and a conventional content analysis performed by two of the authors both independently and collaboratively in an iterative process.^[19,20] Although the focus groups were initially thematically focused on the entire MHCA, ECT quickly emerged as a key theme early in the study, so, guided by this thematic development and consistent with focus group methodology, all data pertaining to ECT were analyzed for the present paper. Categories were identified and related categories incorporated into higher-order categories. Data were analyzed using NVIVO (Version 12.0).

RESULTS

Three focus groups were carried out in December 2017 prior to formal commencement of the MHCA, and six were carried out during implementation in November 2018, although key elements of the legislation had not yet been implemented in practice at that point (e.g., MHRBs to review certain admissions had not yet been established). Three groups were conducted in stand-alone psychiatric hospitals, five at professional development meetings in psychiatric units in general hospitals, and one in an external professional development group.

Table 1 shows the demographic and professional characteristics of our focus group participants. In total, 61 individuals participated in the research. Fifty-six were consultant psychiatrists, and the others were senior clinicians or administrators.

Although the focus groups were initially focused on the entire MHCA, ECT quickly emerged as a key theme that arose spontaneously in all nine focus groups. While focus group methodology does not permit quantitative analysis of individual participants' views, all groups were supportive of ECT in general. One group stated that limitations on ECT were their greatest concern with the MHCA. Eight groups felt that the MHCA was negative for patients in terms of ECT, whereas one group welcomed the additional regulations and ban on unmodified ECT. Four groups strongly supported being able to give unmodified ECT; two did not express a clear consensus, and three supported the ban. Three groups held the view that ECT was totally banned in minors.

Three focus groups raised the issue of resource limitations in relation to ECT, noting that deficits in

Table 1: Demographic and professional characteristics of mental health professionals who participated in focus groups

	FG1	FG2	FG3	FG4	FG5	FG6	FG7	FG8	FG9	Total
Number of participants	8	6	7*	6	6	6†	10	6	6	61
Male	87.5% (7/8)	83.3% (5/6)	85.7% (6/7)	33.3% (2/6)	100% (6/6)	66.7% (4/6)	100% (10/10)	66.7% (4/6)	50.0% (3/6)	77.0% (47/61)
Mean years of experience (range)	18.6 (5-39)	16.3 (8-33)	12.4 (8-25)	5.0 (0-16)	1.3 (5-2)	17.8 (5-35)	17.7 (12-35)	16.2 (4-35)	19.0 (5-40)	14.2 (0.5-40)
Working in urban settings	100% (8/8)	50% (3/6)	85.7% (6/7)	100% (6/6)	100% (6/6)	100% (6/6)	100% (10/10)	100% (6/6)	100% (6/6)	93.4% (57/61)
Working in rural settings	12.5% (1/8)	50% (3/6)	57.1% (4/7)	0% (0/6)	0% (0/6)	16.7% (1/6)	30% (3/10)	0% (0/6)	0% (0/6)	19.7% (12/61)
Public practice	87.5% (7/8)	100% (6/6)	100% (7/7)	100% (6/6)	100% (6/6)	100% (6/6)	50% (5/10)	16.7% (1/6)	16.7% (1/6)	73% (45/61)
Private practice	25% (2/8)	0% (0/6)	0% (0/7)	16.7% (1/6)	0% (0/6)	33.3% (2/6)	90% (9/10)	100% (6/6)	83.3% (5/6)	40.1% (25/61)
General adult psychiatry practice	100% (8/8)	100% (6/6)	85.7% (6/7)	83.3% (5/6)	83.3% (5/6)	83.3% (5/6)	100% (10/10)	83.3% (5/6)	100% (6/6)	91.8% (56/61)
Liaison psychiatry practice	37.5% (3/8)	33.3% (2/6)	42.9% (3/7)	16.7% (1/6)	66.7% (4/6)	50.0% (3/6)	40% (4/10)	66.7% (4/6)	50.0% (3/6)	44.3% (27/61)
Academic psychiatry	25% (2/8)	100% (6/6)	71.4% (5/7)	50.0% (3/6)	83.3% (5/6)	0% (0/6)	30% (3/10)	16.7% (1/6)	16.7% (1/6)	42.6% (26/61)
Old age psychiatry practice	50% (4/8)	16.7% (1/6)	14.3% (1/7)	16.7% (1/6)	50.0% (3/6)	66.7% (4/6)	40% (4/10)	16.7% (1/6)	33.3% (2/6)	34.4% (21/61)
Forensic psychiatry practice	25% (2/8)	16.7% (1/6)	0% (0/7)	16.7% (1/6)	16.7% (1/6)	33.3% (2/6)	10% (1/10)	0% (0/6)	0% (0/6)	13.1% (8/61)
Child and adolescent psychiatry practice	50% (4/8)	50% (3/6)	28.6% (2/7)	33.3% (2/6)	83.3% (5/6)	33.3% (2/6)	30% (3/10)	33.3% (2/6)	16.7% (1/6)	39.3% (24/61)
Intellectual disability psychiatry practice	12.5% (1/8)	33.3% (2/6)	28.6% (2/7)	16.7% (1/6)	50.0% (3/6)	33.3% (2/6)	0% (0/10)	33.3% (2/6)	0% (0/6)	21.3% (13/61)
Addiction psychiatry practice	87.5% (7/8)	50% (3/6)	57.1% (4/7)	33.3% (2/6)	66.7% (4/6)	83.3% (5/6)	70% (7/10)	16.7% (1/6)	50.0% (3/6)	59.0% (36/61)
Inpatient work	75% (6/8)	100% (6/6)	100% (7/7)	100% (6/6)	100% (6/6)	83.3% (5/6)	100% (10/10)	33.3% (2/6)	83.3% (5/6)	86.9% (53/61)
Outpatient work	100% (8/8)	100% (6/6)	85.7% (6/7)	100% (6/6)	100% (6/6)	83.3% (5/6)	100% (10/10)	100% (6/6)	100% (6/6)	96.7% (59/61)

Clinicians were encouraged to tick all descriptions that applied to them. FG – Focus group. *Included the hospital's heads of nursing, social work, and occupational therapy. †Included one consultant anesthetist responsible for ECT in the hospital and the hospital's most senior mental health administrator, ECT – Electroconvulsive therapy

human resources necessitated the use of unmodified ECT in rural areas and that a paucity of trained staff and trained MHRB members might limit access to ECT in the future. Seven of the nine focus groups supported the use of ECT in minors and were very concerned about the limitations imposed by the MHCA.

Overall, ECT generated some of the most emotionally charged responses in the study. Four main themes emerged that directly related to ECT [Table 2] and two more emerged that were indirectly related to ECT [Table 3]. These six key themes are now each discussed in turn in more detail.

Themes directly relating to ECT

The benefits of ECT

The professionals we interviewed were highly supportive of ECT [Table 2]. They described their departments as “ECT friendly” and their use of ECT as “liberal”. ECT was described as “life-saving” in two-thirds of the groups. They referenced many anecdotes in support of

ECT but also talked about both published literature and local research. Many highlighted the severity of cases presenting to them and a long duration of untreated illness as justifying the need for ECT. They felt that many patients did not have other viable options:

“Most of us have prevented suicide ... with ECT, but now our hands are tied.”

ECT in minors

The strongest opposition to the new legislation concerned the restrictions on ECT in minors; this topic often evoked angry statements concerning the MHCA. Many psychiatrists whom we interviewed practiced ECT in minors. Two subthemes emerged:

First, many psychiatrists stated that the MHCA prohibited minors from receiving ECT (although it can, in fact, be authorized). Some believed that this prohibition was in the MHCA, whereas others acknowledged that ECT in minors was possible but that administrative constraints would amount to a *de facto*

Table 2: Key themes and subthemes identified from focus groups directly relating to ECT

Theme	Subtheme	Key quotes
Benefits	Life-saving nature	“ECT is a life-saving therapy.” “It works; it works wonders.”
	Evidence base	“We have robust data to say that unmodified ECT is safer than modified ECT, which is safer than antidepressants.” “We shared data from our institute that we have been using ECT for the last 60 odd years.”
	Vignette or personal story	“Every time he has mania, the only thing he responds to is ECT ... But in a manic phase, he will refuse. But after a couple of sessions of ECT, he comes back to himself. Nothing works with him except ECT.”
	In severe cases	“We have to take permission from them [MHRBs], but the patient is violent and highly suicidal. It will take a lot, maybe three to four days.”
Minors	Prohibition	“This Act doesn’t allow it.”
	MHRB role	“They have talked about minors. You need to go to the District Review Board; Fine if you win the review.” “The Review Boards - Who knows what they’re actually going to advise on, what they’re actually going to do.” “Even in a set up like this, we have serious problems getting an anesthetist because there is a paucity of anesthetists.” “And we have not seen any significant problems with unmodified ECT. In fact, we can say that in many aspects it is better than the modified ECT.”
Unmodified ECT (i.e., without anesthetic)		
Acute phase	Emergency treatment	“Of course, there are institutions and psychiatrists who do give ECT within the first 24 h; Now, under the [new legislation], that cannot happen.”
	Early in admission	“That is our concern there: that ECT will be less used and particularly when there is a definite need in terms of emergency.” “You can treat for 72 h, and we are not allowed to give ECT in those 72 h.”

ECT - Electroconvulsive therapy, MHRB – Mental Health Review Board

Table 3: Key themes and subthemes identified from focus groups indirectly relating to ECT

Theme	Subtheme	Key quote
Resource limitation	Professionals	“We are not able to give unmodified ECT. And again we have to beg for anesthetists.”
	Infrastructure	“We need to improve the resources so that we can give those kinds of services.” “People from remote places are visiting faith healers. First, they have to get the proper psychiatrist; That would be our first objective.”
Non- medical models of mental health	Personal finance	“In many private set-ups, if you had an anesthetist for the ECT, the expenses or cost of ECT will also be too much.”
	Drafting legislation	“The Act was discussed here before going to Parliament. This draft was discussed, and there were a lot of protests. But it was dismissed by giving the reference of the United Nations’ Convention on the Rights of Persons with Disabilities.” “... Psychiatrists feel that their concerns, their viewpoints, have not been given as much importance as the views and opinions of other stakeholders like patients or care-givers and nongovernmental organizations.”
	MHRBs	“Psychiatrists do not have proper representation on any committee, on any board.” “Medical decisions should be left to medical people.”
	Patients	“They [nongovernmental organizations and the anti-ECT lobby] are strongly against ECT. They have created lots of anger about ECT and these patients and families are rejecting ECT.”

ECT - Electroconvulsive therapy, MHRB – Mental Health Review Board

prohibition. Second, many psychiatrists felt bureaucracy and MHRBs could greatly delay ECT in a minor.

Only one group saw any positive aspect to the limitation of ECT in minors. In that group, one psychiatrist mentioned that they felt that the new legislation offered a degree of protection:

“I would prefer a judicial review rather than a police review.”

Unmodified ECT

The prohibition of unmodified ECT also produced strong reactions, but there was less consensus on this issue compared to ECT in minors. The vast majority of psychiatrists reported never having delivered unmodified ECT; none currently delivered it. Many groups welcomed this prohibition, especially younger psychiatrists. The CRPD in general and its prohibition of torture or inhumane treatment in particular were quoted as a justification for the change.

Many psychiatrists argued against the prohibition, especially in emergency cases or circumstances in which muscle relaxants or general anesthesia might be unavailable or contraindicated. Some participants expressed a preference for unmodified ECT.

One focus group raised the issue of “anesthetist’s availability and cost” as a major driver of unmodified ECT. They suggested that poorer families might opt for unmodified ECT. These views on unmodified ECT were more prominent in Bihar and Jharkhand, compared to Maharashtra. There was limited consideration given to the complications of unmodified ECT. Negative long-term complications were not discussed; instead, the psychiatrists focused on the implications of untreated illness.

ECT in the acute phase

The delivery of ECT in the acute phase was raised in many groups. Multiple focus groups stated that ECT could not be used in the emergency setting, especially in the first 72 h. This was another area where many psychiatrists were unclear about the legislation; that is, the understanding of “emergency treatment” in practice differed significantly from the MHCA itself (see Discussion).

Another issue concerned how long it will take MHRBs to make decisions and their suitability to make such decisions in the first place. The potential for the delay was of particular relevance in the acute phase. Some focus groups were also unclear about the use of ECT in an individual admitted on a “supported” basis and how “advance directives” and “nominated representatives” could be used and challenged.

Themes indirectly related to ECT

Resource limitation

Resource limitation was one of the most consistent themes in our study. It arose in relation to almost every topic in every focus group [Table 3]. There were particular concerns about the numbers of trained mental health professionals. Apprehension was also expressed that there was no capacity to train more staff. The lack of professionals related to ECT in several ways. For example, the lack of doctors and nurses prolongs the duration of untreated illness, increasing the severity of presentations.

Many psychiatrists reported that they did not have the resources to do the procedural work needed to deliver ECT. A lack of anesthetists was identified by three groups as a reason for requiring unmodified ECT. The lack of appropriate staff for MHRBs made the psychiatrists uncertain if they could carry out their role:

“We have Review Boards where the people who will be there have no idea what mental illness is.”

The current judicial infrastructure could also greatly delay treatment on occasions when MHRB decisions are challenged:

“The resources are not available, and we are tied down by various laws and norms. They are good. Definitely, they are ideal. But first of all, the platform has to be ready to launch something which is big and ideal.”

The limited financial resources of patients and families came up multiple times and was given as a reason for requiring unmodified ECT.

The impact of the nonmedical model on mental healthcare

This was another one of the most consistent topics that arose in our focus groups, and it was seen as impacting directly on ECT. Psychiatrists felt that parties with a social model of mental healthcare were exercising disproportionate influence at multiple levels, including during the drafting of the legislation. Focus group participants also raised concerns about the decision-making ability of the MHRBs as well as the ability of patients to make healthcare decisions themselves.

There was much concern about how the MHCA was drafted. One group described the drafters as “anti-psychiatry.” Other groups stated that they and the Indian Psychiatric Society had limited involvement in the drafting. The role of nongovernmental organizations in drafting was extensively discussed.

Apart from the drafting of the new legislation, participants saw the role of nongovernmental

organizations as mixed: many highlighted benefits, but when it came to their influence on ECT in the MHCA, psychiatrists were more critical:

“The nongovernmental organization lobby was very strong because everywhere outside of the hospital, a negative picture of ECT has been portrayed and they selectively, or maybe deliberately, undermined the positive effect of ECT.”

There was an impression in many of the focus groups that the new legislation represents international rather than Indian standards and is “borrowed from established developed nations.” Some described the MHCA as “un-Indian.”

Psychiatrists were especially disturbed by how little influence they feel they will have on MHRBs:

“When to give ECT, when not to give ECT — it’s a medical decision. It should not be dictated by nonmedical people.”

Concerns were raised about the scientific and psychiatric literacy of patients. The time constraints on Indian psychiatrists led some to feel that they would not have sufficient time to deliver the level of psychoeducation required to help patients to make fully informed treatment decisions. One focus group of psychiatrists expressed concern that there will be ongoing hostility toward ECT from nongovernmental organizations and that they will attempt to influence patients’ advance directives to further limit ECT use. This was not a view commonly expressed, and it was challenged in the one group where it was brought up.

A repeated observation, from multiple groups, summed up the divergent perspectives of psychiatrists and legislators in relation to the new legislation:

“The ground reality is different.”

DISCUSSION

Overall, we found that many of the themes and concerns commonly associated with ECT in other jurisdictions are readily apparent among Indian psychiatrists, although perspectives on specific issues remain heterogeneous. The one area of near-universal agreement was Indian psychiatrists’ affirmation of the effectiveness of ECT. There were three main areas of concern: the MHCA’s ban on unmodified ECT, ECT in minors, and ECT in the acute phase. Two broad additional themes also emerged: resource limitations and the impact of nonmedical models of mental health. We identified a need for greater education about the MHCA among all stakeholders.

The idea that the MHCA completely prohibits ECT in minors is seen not just in our focus groups but also in

general media.^[21] In practice, it is indeed possible that delays in approval by a MHRB [Section 80 (4)] could result in *de facto* prohibition. This would accord with what many of the psychiatrists whom we interviewed felt would happen, and with the World Health Organization’s (WHO) direction that ECT in minors should be stopped.^[22]

The WHO is also seeking to ban unmodified ECT.^[22] In 2012, the Indian Psychiatric Society, the Indian Association of Biological Psychiatry, and the Indian Association of Private Psychiatry released a position paper on unmodified ECT that questions its negative impacts and advocates for its use in exceptional circumstances.^[23] Some of these topics emerged in our focus groups too, along with other arguments, such as the use of unmodified ECT to reduce costs for patients’ families. There is now an extensive literature on this topic in the Indian literature.^[23-26]

In 2018, following the new legislation, the Indian Psychiatric Society submitted a writ petition to the High Court of Mumbai, arguing that elements of the MHCA violate the right to equality and consequentially right to life of mentally ill people, as enshrined in the Constitution of India.^[27] The writ argues that prohibition on unmodified ECT is not evidence-based and will significantly limit mental healthcare in India. This is consistent with the view that many Indian psychiatrists see unmodified ECT as a necessary therapeutic compromise in light of resource limitations, in order to treat the seriously mentally ill persons.

Our focus groups expressed considerable concerns about the MHCA’s provisions relating to ECT in emergencies. Section 94 (3) of the legislation (“Emergency treatment”) states that “nothing in this section shall allow any medical officer or psychiatrist to use electroconvulsive therapy as a form of treatment.” This effectively bans the provision of ECT on an emergency basis. Section 94 (4), however, states that “the emergency treatment referred to in this section shall be limited to 72 h or till the person with mental illness has been assessed at a mental health establishment, whichever is earlier”. As a result, it appears that the emergency period ends the following assessment in a psychiatric hospital and so – presumably – the ban on emergency ECT is no longer relevant because the “emergency” is then deemed to be over. Greater clarity is, however, needed on this point, as was repeatedly evidenced in our focus groups.

This issue – like virtually all issues raised in our focus groups -- is also linked with recurring concerns about resource limitations in Indian mental health services. There is strong evidence to support these concerns. In 2016, the *National Mental Health Survey of India*,

2015-2016 highlighted the burden of mental health problems in Indian society.^[28] It estimated that 11% of Indian adults suffer from a mental disorder, with 150 million people in need of mental health interventions. In addition to large treatment gaps (up to 92% for some disorders), there are also variations in service availability across the country, with especially limited services in rural areas, although the picture is complicated by the practice of traditional medicine.^[29,30] Financial resources are grossly inadequate, with less than 1% of the national healthcare budget spent on mental health. In addition, there are very significant human resource limitations.^[29] These concerns all clearly informed the views of the psychiatrists in our focus groups.

Focus group participants were also deeply concerned about the impact of the nonmedical model of healthcare. Many of these concerns stem from the fact that the theoretical underpinnings of mental health legislation have been changed by the CRPD, especially in India.^[1] Clearly, modern psychiatry needs to become increasingly rights based and patient centered if it is to accord fully with the CRPD. Interestingly, the drafting of the CRPD mirrored many of the tensions that are seen in the implementation of India's MHCA: strong, well-organized lobby groups pushed for the exclusion of any coercive practices, whereas medical professionals and other groups attempted to forge a more moderate course.^[31,32]

In a fashion similar to what is happening under the MHCA with unmodified ECT, there were petitions right up until the last minute during the drafting of the CRPD for some emergency provisions to be included to allow forced interventions in extreme circumstances.^[33] If Indian psychiatrists are concerned that the provisions of the MHCA are the narrow end of the wedge and that further limitations are to come, recent interpretations of the CRPD strongly affirm their concerns. In 2014, the Committee on the Rights of Persons with Disabilities, which interprets the CRPD, went even further by explicitly objecting to all coercive treatments, thus challenging a key aspect of mental health legislation in most countries (including India).^[34]

Limitations

Our study would have been enhanced by a collection of complementary quantitative data to augment our focus group findings. Although we believe we reached theoretical saturation in our focus group data, our work was complicated by the evolving implementation of the MHCA during the study. Notwithstanding this fact, our sampling of a wide range of Indian psychiatrists revealed very consistent themes across our work. No new topics or themes arose in the later focus group that had not already emerged in earlier ones.

Our focus group participants would ideally have been randomly sampled from an extensive list of potential participants, from a wide range of Indian states. As a result, our sampling method may limit the generalizability of our findings. It could also be argued that individuals who agreed to participate in our study were not a representative sample, due to selection bias. Although our participants may represent a more outspoken cohort, they were by no means homogenous in their views on the new legislation, suggesting that we captured a good range of views in our work, despite any possible sampling limitations.

Even so, our sampling method might still affect generalizability because most of the psychiatrists who participated were working in urban settings (93.4%). These practitioners might have a different viewpoint regarding ECT compared to those practicing in rural settings where resources are very limited. Our findings need to be interpreted with this in mind. Future work could usefully address this issue by focusing on psychiatrists and other mental health practitioners working in rural settings.

At locations where two focus groups were conducted, senior staff who were longer in practice were included in focus groups separate from other staff, in an attempt to minimize group heterogeneity.^[15] While this recommended technique has the benefit of reducing the effect of power dynamics,^[16] it might also introduce bias. Future studies with groups of mixed seniority might yield different or additional insights in the future.

Three of the researchers involved in this work are not primarily based in India. This facilitates a position of equipoise at the focus groups, brings an international perspective to this work, and allows these authors to be more objective about their findings. However, it also necessitates input from India-based co-investigators and co-authors to provide an understanding of this legislation on the ground, as they do in this paper.

Finally, the study period for these focus groups was between November 2017 and November 2018, but some of the key elements of the new legislation were not implemented fully in practice during this period. While we sought to identify issues and problems prior to full implementation, it would nonetheless be informative to perform such focus groups following a full implementation. We hope to do so over the coming years as the legislation is rolled out.

CONCLUSION

The perspectives of Indian psychiatrists on ECT within the MHCA are very considered but also

heterogeneous. Their one area of near-universal agreement is their affirmation of the effectiveness of ECT. Key concerns relate to the legislation's ban on unmodified ECT, ECT in minors, and ECT in the acute phase. Two broad additional themes also emerged in our focus groups: resource limitations and the impact of nonmedical models of mental health, with a perception that theoretical perspectives are driving legislative changes that do not reflect "ground realities" in India. As a result, our work highlights both the problems with the MHCA and ECT at one level and misconceptions among mental health professionals at the other end.

Overall, India's MHCA is an ambitious attempt at rights-based, patient-centered mental health law and, for many reasons, it deserves close international attention.^[35,36] The impact that it has on the use of ECT in India should be watched especially closely, as this pattern is likely to be repeated in many other countries as they reform their mental health laws over the coming years to better align with the CRPD.

Finally, while it has been important to describe the concerns of Indian psychiatrists as they face into the new legislation, it remains to be seen how this pioneering law will work out in practice. On the one hand, some of the concerns raised in our focus groups may prove disproportionate, but, on the other hand, unanticipated issues may arise. What is already clear, however, is that while the MHCA offers significant opportunities for Indian psychiatry, failure to resource its ambitious changes will greatly limit the use of ECT in India.

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There are no conflicts of interest.

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APPENDIX: QUESTIONING ROUTE FOR FOCUS GROUPS

Phase		Question	Timing
Opening	1	Please tell us your name, where you practice psychiatry, and what you enjoy most when not practicing psychiatry.	15 min
Introduction	2	Please tell us about your use of mental health legislation.	10 min
Transition	3	When did you start to hear about the MHCA and what were your first impressions of it?	10 min
Key	4	What have you been pleased to see in the new MHCA?	15 min
	5	Do you have any concerns about the MHCA?	15 min
	6	How do you think the transition between the old Act and the new Act is being managed?	15 min
Ending	7	If you were writing the legislation, what would you have done differently?	10 min
	8	Is there any major area that we have not talked about today that you feel is very important concerning the MHCA?	10 min

MHCA – Mental Healthcare Act 2017

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Editorials

Editorial

The right to mental healthcare: India moves forward

Richard M. Duffy and Brendan D. Kelly



In 2018, India's Mental Healthcare Act 2017 granted a legally binding right to mental healthcare to 1.3 billion people, in compliance with the Convention on the Rights of Persons with Disabilities. Many countries, including the UK, ratified the Convention but only India has stepped up to the mark so dramatically.

Declaration of interest

None.

Keywords

Human rights; low- and middle-income countries; psychiatry and law; psychosocial interventions; service users.

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There are gross inequities in the distribution of health and healthcare worldwide. This is the single greatest bioethical issue of our times. In January 2017, the World Health Organization pointed out that law plays a 'vital role' in realising the 'right to health'.¹

Mental healthcare is a good example. Depression is the leading cause of disability worldwide and approximately 800 000 people die by suicide each year. Despite these figures, most people affected by mental illness – 75% in many low-income countries – cannot access treatment.² This reflects failures of medicine, politics and human rights.

In India, the *National Mental Health Survey of India, 2015–16*, the most ambitious epidemiological survey to date, showed a treatment gap of 85% across the country for common mental disorders and highlighted the profound existing challenges that new rights-based legislation in India is designed to address.³

There is an extensive literature on the concept of the 'right to healthcare' as a potential solution to this problem.⁴ But despite some compelling arguments in favour of rights-based approaches, there is still a lack of data about the effectiveness of creating a legally enforceable right to healthcare. Does it really work? Or do the transaction costs exceed the benefits?

There is currently a unique opportunity to study the effects of a legally binding right to mental healthcare as India's Mental Healthcare Act 2017 came into effect on 29 May 2018, granting a legally binding 'right to access mental healthcare and treatment' to India's population of 1.3 billion people, one-sixth of the planet's population.⁵ India's new legislation contains many ambitious and progressive measures but none is more ambitious than the granting of this fully justiciable right, which can be pursued in the courts. The challenge is great but the vision is greater still.

In 1948, the United Nations' Universal Declaration of Human Rights stated that 'everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control' (Article 25(1)).

But this Declaration is not strictly legally binding and controversy has always surrounded its inclusion of economic and social

rights, given their inevitable relationship with a country's political and economic situations. In 1966, two separate covenants were adopted: the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights. Civil and political rights were to be implemented immediately, whereas economic, social and cultural rights were to be implemented progressively as countries developed at different rates.

This makes good, practical sense because granting legally binding rights is not always the most reasonable or efficient way of achieving social goals. Policy measures can be more pragmatic and effective. It is not sensible to describe all human needs as 'rights'. But what if certain basic human needs are clearly not being met through policy, as is patently the case with mental health need? When should law step in, and how?

India's Mental Healthcare Act 2017 was designed 'to provide for mental healthcare and services for persons with mental illness and to protect, promote and fulfil the rights of such persons during delivery of mental healthcare and services' (Preamble).

There are many interesting aspects to India's legislation, including new admission procedures, reviews of admissions, advance directives and *de facto* decriminalisation of suicide.^{6–8} Most dramatically, however, the new legislation states that 'every person shall have a right to access mental healthcare and treatment from mental health services run or funded by the appropriate Government' (Section 18(1)).

This 'shall mean mental health services of affordable cost, of good quality, available in sufficient quantity, accessible geographically, without discrimination on the basis of gender, sex, sexual orientation, religion, culture, caste, social or political beliefs, class, disability or any other basis and provided in a manner that is acceptable to persons with mental illness and their families and caregivers' (Section 18(2)).

The detailed provisions in this section reflect current best practice in psychiatric care by outlining a minimum package of services to be provided. More specifically, the Government 'shall make sufficient provision as may be necessary' (Section 18(3)), including 'acute mental healthcare services' (out-patient and in-patient); 'half-way homes, sheltered accommodation, supported accommodation'; 'services to support family of person with mental illness or home based rehabilitation'; 'hospital and community based rehabilitation establishments and services'; and 'child mental health services and old age mental health services' (Section 18(4)).

The Government shall 'integrate mental health services into general healthcare services'; 'provide treatment in a manner, which supports persons with mental illness to live in the community

and with their families'; ensure that 'long term care' is 'used only in exceptional circumstances, for as short a duration as possible, and only as a last resort when appropriate community based treatment' has failed; and ensure services are available locally insofar as possible (Section 18(5)).

'Persons with mental illness living below the poverty line ... [or] who are destitute or homeless shall be entitled to mental health treatment and services free of any charge' (Section 18(7)). All 'medicines on the Essential Drug List shall be made available free of cost to all persons with mental illness at all times at health establishments run or funded' by the Government, as shall 'essential medicines from any similar list relating to the appropriate ayurveda, yoga, unani, siddha, homoeopathy or naturopathy systems' (Section 18(10)). To achieve this, 'the appropriate Government shall take measures to ensure that necessary budgetary provisions in terms of adequacy, priority, progress and equity are made for effective implementation' (Section 18(11)).

The right to access mental healthcare also includes access to mental health promotion and prevention services and not just treatment and rehabilitation services. As a result, 'Government shall have a duty to plan, design and implement programmes for the promotion of mental health and prevention of mental illness in the country' (Section 29(1)) and 'shall, in particular, plan, design and implement public health programmes to reduce suicides and attempted suicides' (Section 29(2)).

The law recognises the difficulties in meeting these rights without a corresponding duty on Government to develop human resourcing. The legislation states that 'Government shall take measures to address the human resource requirements of mental health services in the country by planning, developing and implementing educational and training programmes in collaboration with institutions of higher education and training, to increase the human resources available to deliver mental health interventions and to improve the skills of the available human resources to better address the needs of persons with mental illness' (Section 31(1)).

This commitment is binding on Government, as are commitments to 'at the minimum, train all medical officers in public health-care establishments and all medical officers in the prisons or jails to provide basic and emergency mental healthcare' (Section 31(2)) and 'make efforts to meet internationally accepted guidelines for number of mental health professionals on the basis of population, within ten years' (Section 31(3)).

Granting a legally binding right to mental healthcare and committing to resource it adequately are very ambitious steps for any country, including India. There are great challenges. Mental health services in India are substantially under-resourced;^{3,9} specific measures, such as new licensing requirements for general hospital psychiatry units, may well hinder care rather than enhance it;¹⁰ and the Act applies 'during delivery of mental healthcare and services' and not, arguably, between episodes of care, when many violations of rights occur such as neglect, homelessness, imprisonment and social exclusion.

But the greatest human rights violation among the mentally ill in India and elsewhere is simply the lack of care. The drafters of India's new legislation have demonstrated wisdom and vision in articulating a legally binding right to such care despite the inevitable challenges and complexities of such a bold move.

If the urgent, practical challenges presented by the Act are addressed effectively through resourcing, policy change and legislative amendment, in partnership with key stakeholders such as the Indian Psychiatric Society, India will have done the world a profound service by stepping forward and making the right to mental healthcare a reality for so many people.

The rest of the world should watch, listen and learn.

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Can the World Health Organisation's 'QualityRights' initiative help reduce coercive practices in psychiatry in Ireland?

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The treatment of mental illness is undergoing a paradigm shift, moving away from involuntary treatments towards rights-based, patient-centred care. However, rates of seclusion and restraint in Ireland are on the rise. The World Health Organisation's QualityRights initiative aims to remove coercion from the practice of mental health care, in order to concord with the Convention on the Rights of Persons with Disabilities. The QualityRights initiative has recently published a training programme, with eight modules designed to be delivered as workshops. Conducting these workshops may reduce coercive practices, and four of the modules may be of particular relevance for Ireland. The 'Supported decision-making and advance planning' and the 'Legal capacity and the right to decide' modules highlight the need to implement the Assisted Decision-Making (Capacity) Act, 2015, while the 'Freedom from coercion, violence and abuse' and 'Strategies to end seclusion and restraint' modules describe practical alternatives to some current involuntary treatments.

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Key words: Coercion, physical restraint, human rights, QualityRights, Convention on the Rights of Persons with Disabilities.

Introduction

Mental health law is being reshaped by the United Nations' (UN) Convention on the Rights of Persons with Disabilities (CRPD) (UN, 2006). Updated legislation often aims to provide mental healthcare to all on a voluntary basis rather than focusing on provisions for involuntary treatment. Rights-based, patient-centred practice is increasingly being adopted; supported decision-making is replacing substitute decision-making; and individual autonomy and capacity are becoming the defining ethic of 21st century psychiatry (Duffy and Kelly, 2020). The UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment has called for 'an absolute ban on restraints and seclusion' (UN Human Rights Council, 2013).

Despite ratifying the CRPD, Ireland has seen an increase in restrictive practices over the last decade (Mental Health Commission, 2019). The Health Information and Quality Authority (2019) has attempted to address this with a recent publication on rights-based approaches in health and social services. Many other countries have explicitly stated their desire to stop seclusion and restraint and have seen reductions in these

practices (Allan *et al.* 2017). Some countries, such as India, have totally prohibited seclusion (Duffy and Kelly, 2019).

Mental Health Commission's review of coercive practices

In December 2019, Ireland's Mental Health Commission released a report on the use of restrictive practices in approved centres (Mental Health Commission, 2019). This, the Commission's ninth such report, found that the use of physical restraint and the duration of seclusion are increasing. In 2018, there were 7,464 episodes of seclusion or restraint in Ireland's mental health services, representing a 56% increase since 2008. There was also a 47% increase in the total number of seclusion hours in 2018 compared to 2017.

The Mental Health Commission report highlighted heterogeneity in the use of coercive practices across different approved centres, although it acknowledged that this can occur for a variety of reasons. Different approved centres and different community health organisations are often not directly comparable, due to the demographics of the populations they serve, staffing levels and access to seclusion rooms. Other countries also see large variations in the use of coercive practices across different services and regions (Lai *et al.* 2019).

The Mental Health Commission stated 'that there is no evidence of a therapeutic benefit associated with the

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use of restrictive practices such as seclusion and physical restraint. There is also limited evidence of restrictive practices reducing behaviours of violence and aggression. However, most approved centres do not have access to a psychiatric intensive care unit, and in a situation where de-escalation techniques are not effective, can be left with last resort options of seclusion, physical restraint or rapid tranquilisation' (p. 27).

The commission seeks to ensure that restrictive interventions are used only where 'strictly necessary, and that any interventions are undertaken safely, and in line with specified Rules and Codes of Practice' (p. 6). It also seeks to ensure that the safest and least restrictive measures are utilised.

'QualityRights' and the CRPD

After signing the CRPD in 2007, Ireland finally ratified it in 2018. This places a legal obligation on Ireland to comply with its provisions. The definition of disability in the CRPD explicitly includes individuals with long-term mental, intellectual or sensory impairments. Article 12 of the convention relates to 'equal recognition before the law'; this has been interpreted to be incompatible with the involuntary treatment of those with mental disorders. It should be noted that, in common with many other countries, Ireland made reservations in relation to articles 12, 14 and 27, meaning that they did not agree to fully comply with those articles.

In 2012, the World Health Organisation (WHO) produced the *QualityRights toolkit* through its 'Quality Rights' initiative. This toolkit comprises 116 criteria divided across five main themes. It aimed to assess and improve quality and human rights in mental health and social care facilities. It was developed to translate international human right standards, in particular the CRPD, into practice by influencing policy and building the knowledge and skills to implement person-centred and recovery-based approaches (Funk and Drew, 2017). These criteria have been used extensively throughout Europe to evaluate mental health practice, although Ireland was not included in the initial evaluation (WHO Regional Office for Europe, 2018). One of the objectives of this initiative is to end all coercive practices in mental healthcare, including seclusion and restraint (WHO, 2019a).

This absolutist stance on coercive measures has, however, been called into question and the arguments against it merit careful examination. Total prohibition may lead to criminalisation, stigmatisation and a widening of the treatment gap for individuals with mental illness (Freeman *et al.* 2015; Appelbaum, 2019). It is also unclear if such a ban is evidence based or ideologically driven (Szmukler, 2019).

QualityRights training resources

In 2019, the WHO QualityRights group released detailed training and advocacy resources that seek to bring mental health practices in line with the CRPD (WHO, 2019b). As a consequence, these resources focus heavily on reducing coercive practices. They include five core training modules which cover human rights, mental health, disability, capacity, recovery and the right to freedom from coercion, violence and abuse. There are also three specialised training modules which address recovery practices, strategies to end seclusion and restraint, and supported decision-making and advance planning.

These modules are designed to be delivered in workshops with teaching provided by multidisciplinary teams, including people with lived experience of mental illness. They are aimed at all people involved in mental health services ranging from service users and family members to clinicians and managers. The modules are flexible and can be tailored to the needs of those attending the meetings.

Four modules are of particular relevance to Ireland's increasing use of seclusion and restraint. First, the module on 'Legal capacity and the right to decide' examines individual legal capacity, calls into question assessments of capacity, and attempts to shift the paradigm from substitute to supported decision-making (WHO, 2019c). From an Irish perspective, commencement of the Assisted Decision-Making (Capacity) Act, 2015 would partly address many of the topics in this module and would also likely help reduce the necessity for coercive practices.

Second, the module on 'Freedom from coercion, violence and abuse' highlights the impact of coercive measures on individuals and the negative perception of these practices in the international human rights community (WHO, 2019d). It proposes practical steps to reduce these practices, looking at the role of training and communication in avoiding such situations in the first place, greater use of comfort (low stimulus) rooms, empowering staff with greater flexibility, considering alternatives to coercive measures in individual care plans, and development of dedicated response teams.

In an Irish context, addressing many of these issues would require increased staffing levels and more training in de-escalation techniques. Staffing levels have been shown to be associated with coercive practices (Starace *et al.* 2018). The individual care plans discussed by the WHO mirror in many ways the integrated care plans currently in use in Ireland, although the latter do not automatically give consideration to potential triggers of disturbed behaviours or specify less restrictive responses when such behaviours occur. It might be useful to add this consideration to the integrated care plans

of inpatients who have been restrained or secluded to try to reduce the requirements for further coercive practices in these cases.

The WHO also considers the role of response teams, who are groups of experienced and trained individuals who use non-coercive approaches to respond to situations that may lead to seclusion or restraint (Smith *et al.* 2005, 2015). Such teams may include peer supporters or community advocates. In parallel with this, enhanced levels of accommodation and flexibility across services may also help address any power imbalances and facilitate more collaborative working between all stakeholders.

Third, the module on 'Strategies to end seclusion and restraint' sees seclusion and restraint as 'wholly inadequate, inappropriate, unacceptable and harmful' (p. 1), 'incompatible with a recovery approach' and 'contrary to the purpose of care' (p. 3) (WHO, 2019a). This document uses a broader definition of restraint than is used in Ireland, describing practices such as 'compelling someone to go to their room' as coercive. A practice such as this would not be recorded in the numbers currently published by the Mental Health Commission in Ireland.

This WHO module expands further on the measures discussed earlier in the document and sets them in a context where seclusion or restraint would be considered. Some of the examples provided may be superficial or over-idealised, but they are, nonetheless, useful starting points for further discussion about how to reduce coercive practices. This module also highlights the importance of patient and carer education in the reduction of seclusion and restraint.

Fourth, the module on 'Supported decision-making and advance planning' provides a more detailed discussion of capacity and suggests that advance care plans should come into effect at a point of the individual's choosing, rather than at a point where they are deemed to lack capacity (WHO, 2019e). This module also discusses the role of a 'Ulysses' clause which would be needed in such a framework in order to protect an individual's right to health (Dresser, 1984). This is a mechanism of consenting, in advance, to treatment that an individual may not consent to, at the time. The individual binds themself to a course of action and waves their right to refuse treatment in a particular context. This module again highlights the need for assisted decision-making legislation, such as Ireland's Assisted Decision-Making (Capacity) Act, 2015, but also hints that such legislation may need to continue to evolve once it is implemented in order to maximise autonomy and protect rights over time.

Many challenges could arise implementing the QualityRights initiative in an Irish setting. The two largest obstacles are the current legislation and mental

health resources. The Mental Health Act 2001 primarily relates to involuntary treatment and hence is highly discordant with the QualityRights principals. Current levels of resourcing in Irish mental healthcare limit the ability to provide the level of support and capacity building envisaged. Resource limitations may also inhibit the ability of services to deliver the training modules, although its cost in an Irish context is yet to be determined.

Conclusion

Both the CRPD and the WHO QualityRights initiative highlight Ireland's international legal obligation to address coercive practices in mental health care. The QualityRights training resources could be a useful tool in reducing coercive practices as they highlight a number of steps that could expedite reform. Coercive measures could be reduced by enhancing training and education for all involved in mental healthcare including service users, family members and service providers. The commencement of the Assisted Decision-Making (Capacity) Act, 2015 would also be a useful step in maximising individual capacity (Kelly, 2019). Finally, increased funding and staffing would allow for additional training, greater flexibility in delivery of care and provision of more person-centred services – all of which would hopefully reduce the use of coercive measures over the coming years.

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Ethical standards

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committee on human experimentation with the Helsinki Declaration of 1975, as revised in 2008. The authors confirm that this editorial did not require ethics committee approval.

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Editorial

The World Health Organization's QualityRights materials for training, guidance and transformation: preventing coercion but marginalising psychiatry

Fiona Hoare and Richard M. Duffy



Summary

The World Health Organization has developed training material to support its QualityRights Initiative. These documents offer excellent strategies to limit coercion. However, the negative portrayal of psychiatry, the absolute prohibition on involuntary treatment and the apparent acceptance of the criminalisation of individuals with mental illness are causes for concern.

Keywords

Human rights; coercion; World Health Organization; QualityRights.

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The World Health Organization (WHO) QualityRights Initiative is doing excellent work in shifting modern psychiatry away from coercive practices, towards rights-based, patient-centred care.¹ However, some of the content of its materials for training, guidance and transformation¹ may undermine the practice of psychiatry and compromise the rights of individuals with major mental illness.

Background

The United Nations Convention on the Rights of Persons with Disabilities (CRPD) and WHO, have sought to reduce coercive measures in mental health treatment. However, the Committee on the Rights of Persons with Disabilities' and the QualityRights Initiative have taken this aim a step further and are seeking to end involuntary treatment, altogether. This position is strongly informed by the Committee on the Rights of Persons with Disabilities' interpretation of Article 12 of the CRPD, which refers to equal recognition before the law. The banning of involuntary treatment is at odds with the majority of jurisdictions current legislation and Freeman et al² have highlighted how this could actually limit the rights of individuals with mental illness. Such a prohibition is strongly divergent from WHO guidance published within the past 15 years, for example the *WHO Resource Book on Mental Health, Human Rights and Legislation* (which has now been withdrawn).

In 2012, the WHO developed its QualityRights Initiative and published the *WHO QualityRights Tool Kit*. This Initiative seeks to translate international human right standards, in particular the CRPD, into practice by influencing policy and building the knowledge and skills to implement person-centred and recovery-based approaches.^{3,4} The development of this toolkit has involved examining current practices worldwide and in doing so has highlighted many important areas for reform.

WHO training.

WHO QualityRights training materials

In 2019, accompanying materials for training, guidance and transformation were published.¹ These materials have five core training modules: 'Human rights', 'Mental health and human rights', 'Legal capacity and the right to decide', 'Recovery and the right to health' and 'Freedom from coercion, violence and abuse'. In addition, there are three specialised training modules, 'Recovery practices for mental health and well-being', 'Strategies to end seclusion and restraint' and 'Supported decision making and advanced planning'.

Supported decision-making

There are many positive elements in the QualityRights Initiative's training material and their objective of realising and protecting human rights in mental healthcare should be widely embraced. The authors drew on a diverse group of global experts to develop strategies to help integrate the CRPD into mental health practices. In particular, the module on 'Legal Capacity and the Right to Decide' provides excellent discussion on supported decision-making. It highlights jurisdictions where good practice is found, for example, in Sweden and Finland where a 'Personal Ombudsperson' and 'Open Dialogue' are employed with good effect. The training materials discuss many complex topics including advance planning and it briefly discusses the possible utilisation of a 'Ulysses Clause'.

Promoting recovery

There is an important dialogue on the promotion of mental health, in the module on 'Recovery and the right to health'. The need to improve the often-neglected physical health of people with mental illness is highlighted. There are practical suggestions for promoting recovery and the role of individualised plans is discussed. The guidance materials utilise case studies, debates and exercises that help engage users with the concepts of human rights and recovery. There are useful guidelines for the development of peer support groups and advocacy for mental health.

Reducing coercive practices

The availability of the QualityRights training online has the potential to reach a wide range of stakeholders. Importantly, there are excellent suggestions for reducing coercive practices. Such strategies include increased staff training, particularly in communication techniques. There is a useful discussion on the effectiveness of supportive environments and comfort rooms. Response teams are proposed as a way of providing specialised and individualised intervention in periods of distress and reducing restraint and seclusion practices.

Limitations

Unfortunately, there are three significant limitations, and it is important to address these. First, there is a negative portrayal of psychiatry and psychopharmacology. Second, any involuntary practices are characterised as human rights abuses. Third, there is a disturbing acceptance of the criminalisation of individuals with severe mental illness.

Portrayal of psychiatry and psychopharmacology

Psychiatry is portrayed in an unbalanced manner, with multiple negative descriptions throughout the guidance materials. Psychiatrists are mentioned at least 16 times, 13 of those references are negative. Practitioners are portrayed as unsympathetic, dismissive and heavy handed in prescribing medication. This is stigmatising of the profession and could create a further barrier to individuals accessing healthcare.

Similarly, psychotropic medication is represented in a highly negative light. There are multiple references to the adverse effects of medication, at least 14 references to medications were identified none of which mentioned the advantages of pharmacological interventions. Psychotropics have the potential to dramatically improve the quality of an individual's life. Although they are associated with both risks and benefits, this is true of all medication. Their depiction in the training materials does not reflect their robust evidence base.

Along with a misleading portrayal of psychiatry, the authors represent an idealised depiction of psychosocial interventions. One of many examples is found in the 'Legal Capacity and Right to Decide' module, which describes the case of a woman brought to an emergency department by the police after threatening to jump off a bridge. The woman receives psychosocial support from a nurse and her suicidal ideation resolves. Psychosocial interventions are portrayed as highly effective. Unfortunately, there is very little discussion of solutions that may need to be used should such interventions prove ineffective. It is well recognised that a collaborative multidisciplinary approach provides the best possible model of care for patients. Psychosocial and supportive interventions are often exhaustively employed prior to the use of coercive measures.

Portrayal of involuntary practices

Within the QualityRights materials there are numerous times where gross human rights violations are presented alongside involuntary treatments, in a way that implies that these practices are equivalent. Involuntary interventions remain legal in the majority of jurisdictions and until recently were endorsed by the WHO.

For example, the Human Rights module describes a woman who is given medication in hospital that made her feel unwell, and she is also subjected to violence and abuse while an in-patient. The material is written in a manner that suggests these two events are equivalent. The module on mental health, disability and human rights includes the sentence 'they [people with disabilities] should not be tortured, beaten, raped or otherwise abused, they should not be given treatment or surgery without their consent, they should not be sterilized

against their will'. Psychiatrists may find it disturbing to know that the WHO views elements of their practice as torture.

Acceptance of the criminalisation of individuals with severe mental illness

There has been much debate around Article 12 of the CRPD and the potential for it to either protect or undermine the rights of people with mental disabilities. Article 12 provides for 'equal recognition before the law'. Freeman et al have argued that granting all people legal capacity at all times irrespective of mental status actually undermines critical rights of people with mental health disability and can jeopardise people's quality of life, their health and their right to liberty.²

Careful consideration must be given to the alternatives to coercive practices and the very real danger of criminalising people who are mentally unwell must be born in mind. The QualityRights Initiative appears to be disturbingly accepting of this.⁵ The 'Legal capacity and the right to decide' module, states that 'People with disabilities can only be detained on the same basis (or for the same reasons) as all other citizens (e.g. following a criminal sentence)' (p. 29).¹ In the QualityRights module on seclusion and restraint it is suggested an individual who poses a risk to themselves or others 'should be stopped in the same manner as you would stop anyone, with or without a disability – such as by involving a specially trained group who are equipped with the skills to manage the situation (e.g. a response team, see topic 10) or alternatively in some instances law enforcement bodies (e.g. the police force)' (p. 21).¹

Sadly, the role of law enforcement managing individuals with acute episodes of mental illness has resulted in many high-profile deaths and use of excessive force. The use of coercive measures by mental health staff is far from ideal, but the alternative suggestions are more problematic.

Conclusions

Despite the concerns raised above, the QualityRights Initiative should have a central role in helping realise the CRPD, limiting restrictive practices and promoting individual autonomy. Many of the suggested practices and initiatives described in the training material are easily implementable and sadly long overdue. However, the negative portrayal of psychiatry and medication in the training material is unhelpful. The vast majority of psychiatrists approach coercive practices as a last resort, after a careful weighing of the risks and benefits and often after extensive discussion with the individual receiving treatment and their family members. Although there is a clear need for enhancing the use of psychosocial interventions and multidisciplinary contribution, these practices are not universally effective. Characterising involuntary treatments as human rights abuses unnecessarily polarises an important debate. Failure to consider contingency plans for individuals with severe mental illness may lead to treatable conditions remaining untreated or to mental illness being addressed in a forensic setting. The QualityRights Initiative appear worryingly accepting of this.

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Author contribution

Both authors reviewed the WHO QualityRights Initiative and training materials for the purposes of this paper. They were both involved in the drafting of the editorial and subsequent revisions. Both authors had final approval of the version submitted for publication and agree to be accountable for all aspects of the work.

Declaration of interest

Richard Duffy is a member of the Human Rights and Ethics Committee in the College of Psychiatrists of Ireland.

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psychiatry in history

Epidemics: wash your hands! The asylum delivery and violent death of Professor Ignaz Philipp Semmelweis; and, the cursed Semmelweis reflex

Greg Wilkinson 

That hand hygiene is the single most important factor in the control of infection flows from Semmelweis (1818–1865), a Hungarian assistant obstetrician, who deduced in 1847 that the incidence of puerperal fever in Vienna's *Allgemeines Krankenhaus* could be minimised by the use of hand disinfection in a chlorinated lime solution. Alas, Semmelweis did not live to reap the full fruits of his discovery, which was rejected, ridiculed and not widely adopted until after his death, via Pasteur's confirmation of the germ theory of disease (1860s) and Lister's (1865) successful surgical practice using a carbolic acid solution.

Codell Carter et al (1995) relate from five surviving documents that on 13 July 1865, now Professor of Obstetrics at Pest, Semmelweis's behaviour was so inappropriate that his wife thought he might be losing his mind. Two weeks later he was examined by his friend, a paediatrician, Dr Bókai, who concluded that he required specialist attention. For 5 weeks his personal, sexual, professional and social behaviour had changed: he drank alcohol immoderately, went with a prostitute, wasted money, his nights were restless, his appetite great, he sweated profusely and he drank water excessively: affective or infective?

On 29 July 1865, János Balassa, Professor of Surgery, with Dr Bókai and Professor Wagner, a physician, wrote a referral committing Semmelweis to a Viennese asylum. That evening, Semmelweis travelled with family to Vienna by overnight train on his way, he thought, to a German spa but, on arrival in Vienna next morning, on a pretext a former colleague, Ferdinand Hebra, a dermatologist, delivered him to the public asylum in Lazarettgasse near the *Krankenhaus*. There is no evidence that Semmelweis was examined or interviewed on admission, of who was in charge of him and who compiled the inconsistent records, contemporaneously or *post hoc*.

Initially he was excited, restless, confused, grandiose and behaving bizarrely: hot head, pulse 120 (subsequently 140). On the middle finger of the right hand there was contusion or gangrene, which he reportedly said 'appeared of itself' (but was not described pre-admission). He was intermittently put in a straitjacket. He fought with the attendant because he would not let him out, and he wanted to jump out of the window. Three (some say six) attendants could hardly control him. Ultimately, he was reportedly blue in the face, trembling and breathing with difficulty: gangrene worsened, boils were everywhere on his extremities and he had 'An abscess (?) corresponding to the left thorax'.

Semmelweis died on 13 August 1865, aged 47. His body was dissected where he had performed autopsies seeking the cause of puerperal fever. His cause of death was, ironically, infection – pyaemia: acute gangrenous osteomyelitis of the middle finger of the right hand and a metastatic abscess extending into the thorax, with 'in the left thorax an ichor source the size of a man's fist' – the said consequence of untreated injuries that Semmelweis received in the asylum.

The Semmelweis reflex is the reflex-like rejection of new knowledge because it contradicts entrenched norms, beliefs or paradigms.

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Letters

Can psychiatry lead the way in legislating for health and wellbeing?

Earlier this year, the World Health Organisation robustly highlighted “the vital role of law” in “advancing the right to health”¹. Psychiatry is the medical field best acquainted with use of legislation in day-to-day clinical care, although for many decades mental health law did little to improve the situation of the majority of the mentally ill; i.e. voluntary patients. From certifying lunacy to building asylums, the evolution of mental health law has been slow, and many countries still retain severely outdated laws focused on involuntary care rather than ensuring access to treatment for all².

Recent revisions of legislation have, however, sought to harmonise mental health law with international conventions on human rights including the United Nations’ Convention on the Right of Persons with Disabilities (CRPD)³. India, for example, is on the verge of enacting its long anticipated Mental Healthcare Bill that explicitly seeks to accord with the CRPD, which commits ratifying countries not only to protect from violations of rights but also “to ensure and promote the full realisation of all human rights and fundamental freedoms for all persons with disabilities”⁴. The Indian legislation is admirably ambitious.

Having done too little to promote the wellbeing of the majority of people with mental illness for the last two centuries, then, might the latest iterations of mental health law finally advocate more effectively for *everyone* with mental illness? And might such legislation also lead the way for health legislation in general, as proposed by the WHO, as other medical specialties follow the Indian example and use legislation more assertively to improve the lives of their patients?

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plans were informed by a fidelity review. Teams targeted specific items from the CRT Fidelity Scale (a median of eight items per team) as the means by which to improve their service. Our trial demonstrated that a service improvement programme, informed by a CRT fidelity review and focused on improving model fidelity, was successful in reducing hospital admissions and CRT patients' readmissions to acute care. Wong and colleagues' suggestion that this could be achieved just as successfully without reference to model fidelity is an untested assertion.

Our exploration of the relationship between CRT Fidelity Scale scores and outcomes involved only 25 teams in the unusual context of a trial. Further research is desirable to establish the relationship between model fidelity and outcomes, and, in time ideally, to refine the CRT Fidelity Scale to include only items demonstrated to constitute critical components of the CRT model.

In the meantime, the CORE CRT Fidelity Scale may not provide a blueprint, but does offer a helpful guide for practitioners and service planners in what an effective, high-quality CRT service looks like. As such, it is recognised as a descriptor of best practice for CRTs in current NHS England policy guidance.³

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Challenges for the implementation of the Mental Health Care Act 2017

I was extremely delighted to read Duffy & Kelly's editorial drawing attention to the National Mental Health Survey of India 2015–2016 and India's Mental Health Care Act 2017.¹ The Indian government states that the new Mental Health Care Act will give access to mental healthcare to all sections of society. The government also intends to 'integrate mental health services into general healthcare'. As India has a large population of 1.3 billion people there might be certain difficulties in implementing the Act.

As we all are aware, there is a dearth of psychiatrists and mental health staff to cater for the needs of the large population. We also know that there are remedies and treatments available in Ayurveda and other traditional methods that are practised in India. I would like to ask the authors' view about how they would recommend the Indian government and the Indian Psychiatric Society addresses the needs of people with mental illness when there is a big treatment gap across the country. It will also be challenging to incorporate the Mental Health Care Act for remedies and management options provided by Ayurveda, yoga and naturopathy, Unani, siddha and homeopathy establishments in the coming days. What would be the authors' view about how India, with a diverse culture, can align its mental health services so that they are at par with higher-income economic countries.

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Authors' reply

The logistical challenges of meeting India's mental healthcare needs are substantial, but not insurmountable. Many Indian clinicians are highlighting potential paths forward; often utilising and building upon pre-existing resources. Trained lay counsellors,¹ and peer support workers² are two good examples of what is possible. Financial and infrastructural investment is also essential particularly to facilitate treatment within the community; half-way homes, sheltered accommodation and supported accommodation are an unmet need.

The incorporation of Ayurveda, yoga and naturopathy, Unani, siddha and homoeopathy into the Mental Healthcare Act presents a unique opportunity. The reality on the ground is that many individuals with mental illness attend practitioners of traditional medicine, who are often highly skilled.³ The exclusion of traditional practitioners from the Act would have been unlikely to stop the use of such services; consequently, their inclusion facilitates their regulation and registration. It brings their establishments under the remit of the Mental Healthcare Act and provides individuals attending their services with the same patient-centred rights-based protections.

Section 106 of the Mental Healthcare Act prohibits mental health professional (including traditional practitioners) from recommending 'any medicine or treatment not authorised by the field of his profession'. This will hopefully prevent all healthcare providers from practising outside of their field of expertise. In meeting the high standards put forward in the Mental Healthcare Act traditional practitioners may need to increasingly collaborate with psychiatry and this presents all parties with opportunities to enhance their treatments and better serve their patients.

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Scapegoating mentally ill people

Thank you for publishing the interesting debate on the ethics of diagnosing psychiatric disorders in public figures.¹ Langford correctly draws attention to the inevitable stigmatisation of all those with mental illness which such public diagnoses would entail, but arguably a more pertinent issue here is that of scapegoating.

French intellectual Rene Girard (1923–2015) claimed that scapegoating, although eschewed by modern ethics, was an important adaptation in human evolution, inducing the unanimity of 'all against one', and thus strengthening group cohesion and curtailing internecine violence.² Applying this Girardian anthropology, I have recently proposed the archetypal scapegoat hypothesis³ on the

Global mental health

The *Lancet* Commission on global mental health and sustainable development¹ was excellent and necessary. We were especially pleased to see recognition of the role of legislation in promoting the global mental health agenda. Historically, mental health has been the branch of medicine most closely aligned with the law, although mental health legislation often came to perpetuate violations of human rights rather than prevent them. The response of mental health professionals to this historical relationship, however, should not be to distance mental health from legislation, but to reimagine the partnership to protect people's liberty and improve services. These benefits are emphasised by WHO in their report, *Advancing the right to health: the vital role of law*.²

India provides an excellent example of a country where potentially positive change is occurring. India's Mental Healthcare Act, 2017 not only decriminalises suicide but provides a fully justiciable right to mental health care,³ despite no equivalent right to general health care being available. The Indian legislators explicitly drafted their new law to accord with the UN Convention on the Rights of Persons with Disabilities (CRPD) and delivered the first serious attempt to align national mental health legislation with the CRPD.³ Although Indian psychiatrists have voiced reasonable concern at elements of the legislation, especially its implementation, they also express optimism about the initiative.⁴ This optimism is important. The field of psychiatry has had a problematic history around the world with respect to human rights, and strong, fair legislation is vital. In the words of Martin Luther King, "the arc of the moral universe is long, but it bends towards justice".⁵

Legislation has a vital role in finally bending the arc of history towards justice for the mentally ill.

We declare no competing interests.

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Letter to the Editor

In the December issue of the *Irish Journal of Psychological Medicine*, Cronin *et al.* (2017) wrote a helpful comparison of the mental health legislations in the Republic of Ireland, England and Wales, Scotland, Ontario (Canada), and Victoria (Australia). The authors examined the regulations concerning coercive practices and explored the influence of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) (United Nations, 2006). They concluded that the legislation in these five jurisdictions 'reflected adherence with international standards and incorporation of human rights-based principles'.

The fact that these pieces of legislation are similar to each other does not demonstrate adherence to international standards. The most comprehensive guideline regarding the content of mental health legislation is the *World Health Organisation's Resource Book on Mental Health, Human Rights and Legislation* (WHO-RB) (WHO, 2005). While these standards were published before the CRPD they still place a strong emphasis on human rights. The WHO-RB includes a 175 item checklist; Kelly (2011) used this checklist to demonstrate the many areas in which the Irish and the English and Welsh laws were non-concordant with these standards. Irish legislation covered only 48.2% of these items while England and Wales met 54.2%. Areas of low concordance included economic and social rights, the protection of vulnerable patients and capacity. The latter may be addressed by the Assisted Decision-Making (Capacity) Act 2015.

Similarly, the fact that these five jurisdictions have been influenced by the CRPD does not mean that they are concordant with it. Many items currently in the Irish Mental Health Act 2001 fail to live up to the standards of the CRPD. This is especially true in the area of involuntary admissions, seclusion and restraint. Human rights groups, especially mental health advocacy groups played a highly influential role in the development of the CRPD (Byrnes, 2014). An individual's right to retain capacity at all times and deinstitutionalisation became non-negotiables in the drafting of the convention (Melish, 2014). Consequently, careful consideration needs to be given to any limitation of liberty or capacity and any measures that may be perceived as coercive or inhumane.

This may explain Ireland's ten year delay in ratifying the CRPD despite signing it in 2007. The CRPD is one of

the main forces driving recent change in mental health legislation, it underpins the evolution of mental health law from a focus on *treatment* to one on *rights*. Despite the clear benefits of the CRPD, it will bring many challenges. Careful implementation of the CRPD will be required as an overly literal application may actually impair the rights of individuals with mental illness (Freeman, 2015).

Much change is needed to deliver pragmatic, rights based mental health legislation, and an unexpected role model is emerging. In April 2017, India passed its new Mental Healthcare Act (MHA), only 9 months later in January 2018 they began to implement it. Both this Act and India's Rights of Persons with Disabilities Act (RPDA) 2016, were explicitly written to be concordant with the CRPD. From a theoretical point of view, the Indian legislation addresses more of the WHO-RB's standards than Ireland or England and Wales (Duffy and Kelly, 2017). In an attempt to be concordant with the CRPD India has introduced the concept of supported admission in the place of involuntary admission (MHA, Sections 89 & 90), India has also put a strong emphasis on advance directives (MHA, Sections 5–13) and the role of nominated representatives (MHA, Sections 14–17). The RPDA has replaced the concept of *guardians* and *managers* with *limited guardians* (RPDA, Section 14) and has legislated for social rights. These changes may appear to be only semantic but they are important; they empower individuals to exercise their existing capacity and places an obligation on mental health practitioners to build individuals capacity where they can.

The Indian Act is far from perfect and some may question if it is fully concordant with the CRPD. However, it is a significant attempt to develop human rights based legislation. India's ability to implement such an ambitious change remains to be seen, and in this venture human resource problems may be the limiting factor. One worrying difference is that the agent of coercion could shift from the psychiatrist, with professional standards and comprehensive training, to the nominated representative, who may have competing interests and a limited knowledge or experience in the area of mental health. Nominated representatives will need sufficient support from mental health professionals.

Ireland's hesitation to ratify the CRPD partly reflected a desire to ensure our legislation was concordant prior to ratification. However, political consideration overcame these legislative concerns. This more cautious approach may have been better than that of countries who have ratified it but demonstrated little dedication to modifying non-concordant elements of their legislation. The ratification of the CRPD needs to be

celebrated; it will bring many vital protections to individuals with disabilities and may provide the necessary impetus to revise the relevant legislation. If Ireland really wants mental health law that reflects ‘adherence with international standards and incorporation of human rights-based principles’ we will need a drastic revision of our mental health law, if not an entirely new Mental Health Act. If we are serious about such change, India’s current endeavour deserves our attention. The similarity of our legislation to that of other countries should not assure us of its quality.

Conflicts of Interest

The author declares that no conflicts of interest.

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The limitations of MHC's report on seclusion and restraint, and suggestions for future reports

The Mental Health Commission (MHC) recently published its ninth report on the use of seclusion and restraint (2019a). This document highlights that there has been an increase in both the use of physical restraint and the duration of seclusion over the last 10 years. This was reported in the national media as demonstrating an increase in the use of coercive practices (Cullen 2019). One of the other striking findings contained in this report was the high degree of heterogeneity between the different units and Community Healthcare Organisations (CHOs). Levels of seclusion in the nine CHOs ranged from 9.4 to 70.3 per 100 000 population and levels of restraint ranged from 10.1 to 132.0 per 100 000 population. The report acknowledges that comparison is complicated by a wide range of factors, including culture, practice, staff training, staffing levels, and the severity and prevalence of mental illness.

There is a strong movement internationally to prohibit all involuntary treatments in mental health, which was greatly bolstered by the Convention on the Rights of Persons with Disabilities (CRPD) (2006) which Ireland ratified in 2018. The World Health Organization (WHO) has now embraced CRPD informed policies and, through its QualityRights Initiative, is overtly pushing for an end to all coercive practices (WHO 2019). The QualityRights documents echo the comments of the United Nations Special Rapporteur on torture (United Nations Human Rights Council 2013) who described seclusion and restraint as torture. Consequently, there is a strong onus on Irish mental health services to comprehensively understand the factors that influence this level of variation in the use of seclusion and restraint so that steps can be taken to reduce coercive practices. Four modifications to the seclusion and restraint reports would greatly enhance the quality of the data and, consequently, the conclusions that can be drawn.

First, the report contrasts rates of seclusion and restraint from CHOs that have varied access to seclusion rooms. Levels and duration of restraint may be longer in centres without such facilities, and this may explain some of the observed variation. A CHO with an approved centre without a seclusion room may have lower rates of seclusion compared to a CHO in which all centres have seclusion rooms. However, in this case, the variation would reflect the services available rather than the use of coercive practices. It would be more

informative to only analyse centres with seclusion rooms or to include a discussion on the more comprehensive data in the appendix of the report. Stratification by 'access to a seclusion room' would add clarity to the report.

Second, meaningful comparison between the units and the CHOs is inhibited by the fact that there is no indication of the severity of illness experienced by the individuals attending each service. The wide variation in rates of involuntary admission suggests that different CHOs may have different burdens of severity of mental illness (Mental Health Commission 2019b). This would be hard to collect data on directly; however, HIPE (Hospital In Patient Enquiry) codes would provide some limited information. There are also multiple proxy markers that could be used to give an indication of the acuity of the presentations. For example, days of involuntary admission on the unit, average length of stay (Nielsen *et al.* 2016), percentage of all bed days that are occupied on an involuntary basis, reasons for admission or diagnosis on discharge could provide information that would enhance the generalisability of the data.

Third, in addition to calculating seclusion per population levels in each CHO, levels per bed number or per involuntary days may provide a more informative metric. Levels per bed number can be calculated from the table in appendix 3, but in its current format, direct comparison is not convenient. These would partly give consideration to the level of acuity seen in the different CHOs, and it would also allow a comparison with international levels measured using different denominators.

Fourth, the report makes no mention of restraint brought about through the use of sedating medication in the absence of a clinical indication. The WHO's QualityRights Initiative refers to this as 'chemical restraint' and sees it as a central component of restrictive practice (WHO 2019). The use of pharmacological agents on individuals represents a major confounder in evaluating the use of seclusion and restraint. The collection of these data would require the largest modification, at least for voluntary patients. For involuntary patients, however, some data should exist as the number of service users administered involuntary medication and the number of administrations of involuntary medication used each month are two of the items that the MHC has instructed all approved centres to record (MHC 2014). If these data are being collected, it would be highly informative to see it included in any reporting on seclusion and restraint. For voluntary patients, any data recording the levels of medication used on the

ward would give some indication as to the level of chemical restraint being employed. Even a crude measure would be highly informative, for example, intramuscular medication used on an involuntary basis, or frequency of 'as needed' antipsychotic use, or total dose of antipsychotic used per unit beds. These measures would have severe limitations, but significant trends or highly heterogeneous patterns of use may stimulate further research. The omission of information on chemical restraint makes the rest of the data contained in the report impossible to interpret.

National and international pressure is mounting to reduce, and even prohibit, the use of all coercive measures in the treatment of psychosocial disabilities. Collecting data on the use of seclusion and restraint is a vital first step but developing a deeper understanding of this data is required to modify current practices. The data we have on seclusion are highly informative and recently has demonstrated worrying trends. The high level of variation is a fascinating observation, but due to the nature of the data collected, it is of limited use. Modifications to the data collection, both straightforward and more complex, would greatly enhance the utility of these data and may lead to identifying steps that could help bring the practice of mental health care in Ireland more in line with the CRPD.

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RD has no conflicts of interests.

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Chapters

Book chapter for “Optimizing Patient Care in Psychiatry” (Routledge/Taylor & Francis, USA) edited by Amresh Srivastava, Nilesh Shah and Avinash De Sousa

“Optimizing Patient Care In Psychiatry with Autonomy and Choice”

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Abstract

Driven by the Convention on the Rights of Persons with Disabilities and supported by the World Health Organizations QualityRights initiative, autonomy and patient choice are increasingly becoming the hegemonic ethical principles in rights-based mental healthcare. To optimise patient care, it is important that psychiatry shifts away from simply assessing capacity and instead focuses firstly on building an individual’s capacity. During remission, proactive measures can be used to minimise future coercive measures. Mental health services can and should provide more informal supports to enhance and facilitate communication. For individuals with more severe illness, these services can employ advance directives, nominated representatives and a supported decision-making process to help realise an individual’s rights, will and preference. As mental health legislation currently stands, there does not appear to be an obvious path to fully remove coercion while still protecting the rights of individuals with mental illness. Clearly, steps should be taken during involuntary treatment to minimise coercion and continue to allow individuals to exercise choice where

possible. This can be done within the restraints of local legislation and professional guidelines. Particular consideration is given in this chapter to the perinatal period and the treatment of minors as they can be particularly vulnerable to coercion.

Introduction

Historically, much of the treatment for mental health conditions occurred without an individual's consent (Killaspy, 2006). Many of the old asylums only admitted individuals on an involuntary basis, and only later were provisions made for individuals who chose to be there. Consequently, much early mental health legislation addressed substitute decision-making and supported involuntary admission and treatment. Even today, many jurisdictions' mental health law only considers involuntary patients in detail (e.g. Ireland's Mental Health Act, 2001). This may be partly explained as a remnant from a time when the majority of psychiatric practice occurred on an inpatient basis.

Not until the deinstitutionalisation at the end of the asylum era were comprehensive outpatient services developed for individuals with mental health problems. While the majority of coercive practices now occur in inpatient settings, significant coercion can be present in community based treatment too (Sheehan, 2009; World Health Organization, 2019a). This has been legally formalised in over 75 jurisdictions through community treatment orders (Rugkåsa, 2016).

The role of involuntary treatment is falling under increased scrutiny since the beginning of the twenty-first century. This is predominantly driven by the United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD) (2006). The first of the "General principles" affirmed in Article 3 of the CRPD is "respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons". This has clear relevance in psychiatry.

The most important article in terms of protecting autonomy is Article 12 which refers to equal recognition before the law. It appears to be possible to comply with Article 12 and still make provisions for involuntary treatment (Caldas de Almeida, 2019; Callaghan and Ryan, 2014). However, the UN Committee on the Rights of Persons with Disabilities, which interprets the CRPD, states that Article 12 prohibits *all* involuntary treatment *and* substitute decision-making (2014). It is unclear how this *non sequitur* was arrived at by the Committee (Craigie et al, 2019). Many countries ratified the CRPD with formal reservations against this article, thus stripping it of some of its power (Dawson, 2015).

In addition to these two articles, Article 14 of the CRPD addresses liberty and the security of the person; Article 15 provides protection from torture or cruel, inhuman or degrading treatment or punishment; Article 16 addresses freedom from exploitation, violence and abuse, and Article 17 protects the integrity of the person. The World Health Organisation (WHO) has embraced this emphasis on autonomy and patient choice. Their QualityRights initiative aims to realise an individual-centred, rights-based approach to mental healthcare (WHO, 2012).

Against this background, this chapter examines how individuals' autonomy and preferences can be maximised both in general and during episodes of illness. It puts forward the case for involuntary treatment and discusses how individuals can continue to exercise agency during episodes of such treatment. Women in the perinatal period and minors are given particular consideration due to their vulnerability to coercive practices. Finally, key general underlying principles are highlighted and consideration is given to local legislation.

Limiting coercive practices: general principles

Capacity

As described above, autonomy and choice are key to empowering individuals with mental health difficulties. The concept of capacity is central to helping an individual exercise their autonomy. Many psychiatrists are familiar with assessing capacity, but to optimise the treatment of individuals attending mental health services, psychiatry needs to focus instead on building capacity. Before this discussion is developed, it is important to define both mental and legal capacity, as the term 'capacity' can refer to either concept (UN Committee on the Rights of Persons with Disabilities, 2014). 'Mental capacity' is a measure of someone's ability to make decisions and is dependent on many factors. 'Legal capacity' is 'the ability to hold rights and duties (legal standing) and to exercise those rights and duties (legal agency)' (p.3).

Historically, these two concepts of capacity were treated synonymously and capacity was often seen as both global and static. Indeed, this is still the case in many jurisdictions. An individual was either judged to have decision-making capacity or to lack it. This approach hugely limited, or removed, the individual's legal capacity and once this determination was made it was very hard to reverse (Zaubler et al, 1996). Thankfully, mental capacity is increasingly seen as decision-specific and as something that changes over time. Also, the

concept of mental capacity itself is coming under increased scrutiny (WHO, 2019b) and its direct implications for legal capacity are being reduced. Much of what is discussed in this chapter can be conceptualised as steps to promote the legal capacity of individuals with impaired decision-making capacity.

Capacity is widely discussed and emphasized in the CRPD (UN, 2006) and it is given further attention in the UN Committee on the Rights of Persons with Disabilities (2014). These provisions are affirmed by the WHO, who promote individuals' 'right to exercise their legal capacity on other issues affecting them, including their treatment and care' (p.8) (WHO, 2013). Many of the practicalities of building capacity are also discussed by the QualityRights Initiative (WHO, 2012; WHO, 2019b).

As a result of these provisions, it is important that mental health services promote decision-making ability even when individuals are receiving involuntary treatment. Active encouragement to make decisions and state preferences may be necessary, as individuals may be reluctant to express their views, especially if they feel they might be controversial (Woltmann & Whitley, 2010). Mental health professionals also have a role in advocating for individuals to make choices outside of those relating to treatment options. This may be uncomfortable as professionals may feel that some of this lies outside of their range of expertise. Additional support may therefore be needed to help people make decisions in relation to, *inter alia*, employment, housing, property ownership, financial matters, parenting and family life. Collaboration with social workers, mental health advocacy groups or legal professionals may be of benefit in this context.

In a manner similar to assessing capacity, building capacity can focus on four key areas: understanding, reasoning, appreciation, and expression of choice (Grisso et al, 1997). To promote understanding, information can be presented in a manner that is easily understandable and consideration given to the person's level of educational attainment, learning styles, literacy and culture (Marcus, 2014). The other domains of capacity can be supported by providing individuals with additional time, optimising their treatment and facilitating informal support from friends, family and advocates. It is important to be aware that the relationship between the decision-maker and health professional can be more influential than the information provided; this situation has both advantages and disadvantages (Woltmann & Whitley, 2010). More formal supports are discussed below.

Capacity assessments

Before any assessment of capacity occurs, it is vital that individuals have been given every opportunity to accurately represent themselves. As mentioned above, the WHO's QualityRights Initiative holds that mental capacity testing is an invalid concept, as it cannot be measured scientifically, often leads to a denial of legal capacity and is often considered a permanent state (WHO, 2019b). Even with the benefit of the CRPD, the assessment of capacity is a highly complex endeavour and a large element of subjectivity is inescapable (Keene, 2017). Researchers have attempted to overcome the lack of scientific validity through the use of standardised tools such as the MacArthur Competence Assessment Tool (Grisso et al, 1997).

Capacity assessments are also disproportionately applied to people with mental health problems (Series and Nilsson, 2018). An individual without a mental illness is often free to make a choice perceived by others as poor without having their mental capacity called into question. Even in individuals with illnesses that are seen as chronic and enduring, a high level of mental capacity is still retained (Hostiuc et al, 2018). Consequently, it is vital that capacity assessments should not be influenced by the diagnosis but by objective findings.

Informed consent

Informed consent is the main mechanism through which autonomy is protected in the context of healthcare (Murray, in press). Once a mental health professional has supported an individual in optimising their decision-making capacity, it is important that informed consent is sought for any proposed treatment. The clinician is required to convey information that a judicious patient would require, including risks, benefits and alternative options (Cordasco, 2013; Darby & Weinstock, 2018). Seeking informed consent facilitates the therapeutic alliance, enhances trust and increases both patient and doctor satisfaction (Wolf-Braun and Wilke, 2015).

Even when an individual is unable to give fully informed consent, it is important that their perspective is considered. An individual's decision-making capacity may change over time, so it may be important to revisit the decision when indicated. As people improve clinically, they may be able to provide fuller consent, understand more of their treatment options or change their mind. It is important that a lack of decision-making capacity does not deprive an individual of treatment options.

Limiting coercive practices for individuals with severe illness

The measures described in this section can be used with all individuals attending mental health services. They are, however, of greater relevance to people with severe mental illness who are more likely to experience coercive practices. These measures should also be considered for individuals who have been subject to involuntary treatment in the past and for those at increased risk of involuntary treatment in the future (Barnett et al, 2019). In these circumstances, creating an advance directive (AD), appointing nominated representatives and considering a framework for supporting decision-making may be of great value. Even in jurisdictions where there is no legal provision for such tools, these steps can still inform treatment and reduce coercion.

Advance directives

An AD is a statement made by an individual with decision-making capacity, that states how they would like to be treated and/or who they would like to support them should they lose their decision-making ability (Zelle et al, 2015). The QualityRights Initiative is supportive of advance planning documents (WHO, 2019c) and many jurisdictions are making formal legal provisions to this end; India is a good example (Duffy and Kelly, 2019). The use of coercive measures is reduced in individuals with ADs and, in addition to promoting autonomy during an episode of illness, there is evidence that creating an AD within a therapeutic alliance enhances autonomy (Nicaise et al, 2013).

Individuals find the experience of creating an AD to be meaningful and often express positive choices that can inform difficult decisions in the future (Lenagh-Glue et al, 2020; Shields et al, 2013). Despite clinicians' concerns (Duffy et al, 2019), the majority of people make ADs that are in line with the advice of their treating team (Gowda et al, 2018; Shields et al, 2013). While ADs are well accepted by patients, however, rates of utilisation are low (Gowda et al, 2018). Making an advance directive does not need to be time-consuming (Philip et al, 2019a) and uptake can be greatly enhanced by assistance from clinicians (Zelle et al, 2015).

Careful consideration needs to be given to when an individual makes an AD because poor insight or residual symptoms can influence the directive (Gowda et al, 2018). It is important that ADs are as comprehensive as possible and include treatments that the person does not want to receive as well as other domains outside of mental healthcare (e.g. children, property) (WHO, 2019c). Both legislation and individual ADs should consider the contexts in which they want the directives to come into force and the process of deactivating an AD.

Ulysses clause

For ADs to give meaningful protection, they arguably require a mechanism to prevent individuals from voiding them during an episode of illness. This may take the form of a capacity assessment or a ‘Ulysses clause’ (Dresser, 1984). In a Ulysses clause an individual declares ‘that what they have stated in their advance plan should take precedence over their stated wishes and preferences during specific future events’ (p. 50) (WHO, 2019c). This tool is yet to be established as a commonly used legal mechanism and the clear limitations of such clauses need to be clarified. It is beneficial to discuss context in which individuals would like to reconsider their ADs and what protections would they like to see in place should they wish to revoke them during an episode of illness. ADs, including Ulysses clauses, should be regularly reviewed, in particular following an episode of illness.

Nominated representatives

An NR is a trusted person who best interprets a mental health service-user’s will and preference where all other actions have failed to directly obtain the will and preference of the person (WHO, 2019c). This may be due to situations where the service-user is in a state of coma or has profound communication impairment. The WHO (2019b) highlights that, even in such challenging circumstances, ‘we must always strive to find ways to ensure that people have the final say in all decisions concerning their lives’ (p. 2). The articulation of preference might not always be verbal and might involve close family or relatives who were aware of an individual’s preferences, an NR and/or an AD.

It is important to note that NRs are not substitute decision-makers. Rather, they play a supportive role in clarifying and advocating for the service-user’s will and preference (WHO, 2019c). An NR can be elected in an AD or included in separate document, such as care plan or clinical notes. NRs can be revoked and replaced by another preference at any time, although protections like those discussed in relation to a Ulysses clause might need to be considered. An additional NR should be selected if the primary NR is unreachable. An NR is generally a close friend or relative who respects the will and preference of the service-user; they should be easily available and accessible (Jeste et al, 2018). It should be possible for individuals to choose who does and does not support them in their decision-making. If someone wishes not to have a family member support their decision, this should be respected,

especially where this view is consistently held outside the context of illness (Duffy and Kelly, 2017a). To avoid any conflict of interest, the WHO recommends excluding mental health and social service staff (WHO, 2019c). In circumstances where no supportive person is available, an independent person such as an advocate can be appointed temporarily. All measures are then taken to obtain information about the service-user's beliefs, will and preferences (WHO, 2019c).

A good model that has adopted many of these principles is seen in Ireland's new mental capacity legislation (which has yet to be implemented). Ireland's Assisted Decision-Making (Capacity) Act, 2015 recognises a three-level model of decision-making support, depending on the needs of the decider. This support ranges from assistance and provision of information to a Court-appointed representative attempting to ascertain the decider's will and preference (Kelly, 2017). The Indian Mental Healthcare Act 2017 provides another example of legislative provisions for NRs (Philip et al, 2019b).

NRs have the potential to significantly enhance service-user care, satisfaction and autonomy during periods of severe illness. They may help reduce the risk of conflict within families, ensure prompt interventions and avoid the exploitation of vulnerable service-users. Careful protections are, however, required to ensure that an NR does not abuse their role.

Decision-making

ADs and NRs are two of the key constructs in promoting the transition from substitute to supported decision-making. Moving from acting in someone's 'best interests' to acting in line with their 'rights, will and preference' is integral to this transition. Article 12 of the CRPD mandates states to ensure that service-users have access to a range of supports to make their own decisions. This includes friends, family, advocates and many others. The QualityRights Initiative suggests a number of additional mechanisms including a circle of support (Australia and UK), personal ombudsperson (Sweden), personal assistance and open dialogue (Finland) (WHO, 2019c).

A circle of support revolves around the service-user who invites people to be part of the circle and navigates the direction of the circle. The group support and help the service-user towards their goal. Formal research on this topic is highly limited, but these circles are extensively used in the UK (Circles Network, 2018).

Personal ombudsperson is a model used by non-governmental organisations in Sweden and involves a long-term relationship of trust in which a skilled person supports and

assists the service-user with a range of matters relating to family, housing, employment and accessibility to services (Jespersion, 2013).

Open dialogue is a needs-based, service-user initiated approach to mental health care that emphasises dialogue and shared understanding between service-users and their support networks (Twamley et al, 2020). It involves an open discussion between all participants with an emphasis on the service-user's voice. This process enables sharing of information and better understanding to grow within the group. It has been used to attempt to reduce medication use and hospital admission for people with mental illness.

All of these constructs revolve around the fundamental idea of supporting the service-user to exercise their autonomy and replacing the substitute decision-making model. Mental health services can further facilitate supported-decision making by ensuring accessibility to relevant NGOs, advocates and peer support groups. Supported decision-making is a voluntary process and requires appropriate safeguarding measures that may include limiting the time-period of the acting supporter, involving non-profiting, non-conflicting supporters, and electing independent supporters only.

The case for involuntary treatment

A full exploration of the case for involuntary treatment is outside the boundaries of this chapter. However, some of the key arguments are put forward here. Not all UN and WHO organisations agree with the current position of the Committee on the Rights of Persons with Disabilities (Szmukler, 2019). The interpretation of the Committee might well exceed the intent of the CRPD (Craigie et al, 2019; Independent Review of the Mental Health Act 1983, 2018). Freeman and colleagues (2015) argue that its interpretation might actually undermine the rights of people with mental illness. Untreated illness would erode rights to health, liberty, justice and even possibly life.

It is unclear if the total prohibition of involuntary treatment is what the majority of people receiving treatment want. Surveys of service-users have shown support for the possibility of coercive measures when other options have been exhausted (Szmukler, 2019). Pathare and colleagues (2015) found that a significant majority of service-users recognise the need for a degree of coercion during periods of impaired decision-making. This supports the argument that there has been a lack of consultation between the Committee on the Rights of Persons with Disabilities and the full range of service-users (Freeman et al, 2015). The Committee also excluded experienced clinicians. The UN and WHO agenda appears to be

more ideologically driven than evidenced-based (Craigie et al, 2019). It is also unclear what would replace involuntary treatment and the implications of such a change for people with severe mental illness.

The false belief that mental illness is untreatable and the over-estimation of the association between mental illness and violence contribute to discrimination against, and stigmatisation of, people with experience of mental illness. Allowing individuals with very severe mental illness to remain untreated may perpetuate these stigmatising stereotypes (Appelbaum, 2019). Posing a risk to others remains one of the common grounds for involuntary treatment internationally and the removal of this legal provision could lead to an increase in violence associated with mental illness.

In addition to contributing to fear and stigmatisation, this would also lead to the criminalisation of individuals with mental illness – something of which the WHO's QualityRights programme appears to be worryingly accepting (Duffy and Kelly, in press). Even in the absence of increased violence, a significant increase in the prevalence of untreated psychosis in the community would feed the myth that mental illness is untreatable and increase levels of fear and marginalisation. Scholten and Gather (2017) convincingly argue that this actually diminishes the autonomy of the person deprived of treatment.

If formal involuntary treatment were to be abolished, there is a high likelihood that coercion would be shifted from independent professionals to family members who might engage in coercive practices when medical professionals cannot (Duffy and Kelly, 2017b). Untreated illness puts a further burden on families and carers, and could curtail their rights to health or life either directly (through violence) or indirectly in other ways (Freeman, 2015).

Limiting coercion for individuals receiving involuntary treatment

The absolutist stance concerning autonomy adopted by the QualityRights initiative and the Committee on the Rights of Persons with Disabilities does not reflect the legal reality in many jurisdictions, where involuntary treatment remains a core component of mental healthcare. Until clear alternative pathways for the management of individuals with severe mental illness are found, involuntary treatment will remain a feature in many jurisdictions. Consequently, it is important to consider protections during involuntary care. The WHO's 'Resource Book on Mental Health, Human Rights and Legislation' was published before the CRPD and considers protections in this context (WHO, 2005).

It is vital that the assessment on which involuntary admission is based is comprehensive and carried out by appropriately trained senior clinicians, acting within the local legislative provisions (WHO, 2005). Where this has not occurred during the admission process, it is essential that the admitting team rectify this situation immediately. Ideally, the assessment should be done by two independent practitioners. There must be clear evidence of a mental disorder, but admission should be based on the current clinical presentation rather than the diagnosis. Particularly careful consideration should be given to the involuntary admission of individuals with substance misuse or a personality disorder, even in jurisdictions that permit these as grounds for involuntary admission (Opsal et al, 2019; Stapleton and Wright, 2019).

Once the individual no longer meets the criteria for involuntary detention, their admission status should be changed and they should be informed. Involuntary treatment should last only for as short a period as possible (WHO, 2005).

It is essential that people who are subject to involuntary admission have a right to appeal any admission or treatment that they feel is unwarranted or unjust. This appeal process should be both timely and independent. The involuntary patient themselves might not be in a position to initiate the appeal so it is important that there are mandatory automatic independent review procedures (Deshpande et al, 2008; WHO, 2005). Where this is not necessitated by legislation it can be conducted informally. This process should include an initial evaluation followed by periodic reviews. Free legal representation is needed for the review and appeal process to be effective.

The least restrictive practice should always be adopted and, as part of this, community based and voluntary treatment options should be exhausted prior to considering involuntary admission and treatment. An individual who is subject to involuntary treatment still has a right to comprehensive information about the proposed treatment plan and their assent should still be sought (WHO, 2005). Some of the harmful effects of coercive treatments can be mitigated by the establishment of supportive relationships with the individual, creating a sense of safety, protecting their rights and fostering a sense of agency (Wyder et al, 2016).

Seclusion or restraint, if used, should occur under close scrutiny, the indications should be recorded and details of each episode should be carefully documented. The use of seclusion and restraint can be reduced through staff counselling and training, enhanced communication and risk assessment, service-user participation and careful analysis of all episodes of violence, seclusion and restraint (Dahm et al, 2017; Black et al, 2020). Additional

layers of review should be present for electro-convulsive therapy or psychosurgery and these processes should, again, be comprehensive and independent.

Community treatment orders (CTOs) have long been controversial, not least because the evidence in favour of them is sparse (Kisely et al, 2017) and there is significant evidence against effectiveness (Pai and Vella, 2016). Notwithstanding these facts, CTOs still have a degree of face validity owing to the fact that the community appears to be a less restrictive environment than a hospital. As a result, and despite their questionable evidence base, CTOs are used in over 70 jurisdictions worldwide (Mikellides et al, 2019).

Pridham and colleagues (2016) usefully highlight the fact that coercive elements of CTOs can be minimised, even when CTOs are used. In order to do this, they suggest enhancing patient access to information, fostering better relationships between service-providers and service-users, and making the CTO process fair and transparent. Even when a CTO is in place, extensive consideration should still be given to the individual's preferences and, where possible, these should be accommodated. For example, a person who is on an antipsychotic and unhappy about weight gain could be switched to an alternative medication, as clinically indicated (Alonso-Pedrero, 2019).

Where CTOs exist, it is important that their procedural protections mirror those received by individuals who are admitted on an involuntary basis, so that deinstitutionalisation is not be undermined by CTOs (WHO, 2005). CTOs should be an alternative to involuntary inpatient care rather than an alternative to voluntary community care. The use of CTOs in the context of the criminal justice system is outside the scope of this chapter, but presents a range of complex issues of its own.

In jurisdictions that permit coercive treatments, clinicians should consider using them if and only if they are needed, especially in incidences associated with risk or adverse outcomes. However, extensive steps should be taken where possible to minimise restrictive practices and to facilitate the agency of the individual. This process can take a variety of forms (as discussed above) and is often most effective during periods of remission.

It is also important to consider the position of non-protesting patients who lack mental capacity who are considered to be voluntary patients in many jurisdictions (such as Ireland). These individuals might remain in hospital without protest, but this might not be the result of a fully informed decision. While 'voluntary' status in this situation might appear less restrictive, these people might be deprived of the statutory review and protective processes available to involuntary patients.

As a result, it is essential that ‘voluntary’ non-protesting patients who lack mental capacity receive the same level of protection as involuntary patients (WHO, 2005). This can occur through the periodic review of non-protesting patients or by acknowledging that they are not voluntary patients. India’s Mental Healthcare Act, 2017 requires that an individual seeking an independent (voluntary) admission has the ‘capacity to make mental healthcare and treatment decisions’ or requires minimal support in doing so (Section 85).

This kind of protection enhances the rights of non-protesting patients, although it could also be seen as more restrictive, because such patients might now be classified as supported (involuntary) patients. In a similar manner, voluntary patients who would be detained in the event that they express a desire to leave might be considered to have more legal protection (e.g. a right to review, appeal or legal representation) if they are formally detained. It is important that voluntary patients know their rights and that they are free to leave, but that they can be detained if they meet certain, clearly defined criteria (WHO, 2005).

Special consideration

Women’s reproductive and sexual health

‘Women with disabilities may face even more denial of their right to legal capacity as a result of multiple discrimination’, according to the WHO (2019b, p. 7). While Article 6 of the CRPD places an onus on states to address this issue, many barriers still limit female reproductive and family rights. Women with mental illness often experience additional restrictions that impact on, *inter alia*, access to family planning services, obstetric interventions (Halliday, 2019; Murray, in press) and custody of children (Weller, 2019). Historically, the limitation of these rights was overtly stated in laws such as British Columbia’s Sexual Sterilization Act, 1933 and India’s Special Marriage Act, 1954. Fourteen countries had legislation permitting involuntary sterilisation, many on the grounds of mental illness (Amy and Rowlands, 2018). This form of discrimination has not totally ended: as recently as the 1990s, China introduced legislation permitting the sterilisation of individuals with mental illness (Pearson, 1995).

The complexity of ethics in relation to pregnancy cannot be underestimated and is often done a great disservice by reductionistic ideological perspectives (Kingma, 2018). For the pregnant woman, there is a complex, nuanced balancing of rights and duties which

different jurisdictions, cultures and philosophies commonly seek to influence, often by utilising blunt instruments (Rosamund, 2002). While many jurisdictions (e.g. UK) have established that pregnancy should not inhibit any legal protections for the woman, this position is still far from universally accepted (Murray, in press).

It is essential that women's reproductive health, sexual health and potential role as a parent are considered during interactions with mental health services, not just in a *post hoc* manner when an issue arises (McGuire et al, in press). Women's preferences about contraception, pregnancy, breastfeeding, sexual health, sexual expression and parenting may need to be part of a mental health assessment and, where necessary, should inform their treatment. By considering these during initial assessment, choice and autonomy can be greatly enhanced. Services also need to identify if they limit access to termination of pregnancy and, while this is highly heterogeneous internationally, it is important that mental illness is not used as grounds to reduce access to services.

Article 23 of the CRPD protects the rights to marry, found a family and access family planning; it also prohibits forced sterilisation. An onus is placed on states to 'render appropriate assistance to persons with disabilities in the performance of their child-rearing responsibilities'. The CRPD states that children should only be separated from their parents 'when competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child.'

Another key principle in respect to the right to a family is that parenting ability should not be called into question on the basis of a diagnosis alone. Until recently the majority of the literature on this theme focused on the risk posed by mothers with mental illness, but this approach has now shifted towards describing the capabilities of mothers with mental illness (Weller, 2019). Paradoxically, it can be fear of appraisal and judgement that prevents mothers from seeking treatment for mental illness; this can lead to a major relapse resulting in concerns being raised about child safety. It is important that mental health services emphasize their desire to support mothers in parenting and advocate on their behalf. All of these considerations are even more complex when providing healthcare to individuals with intellectual disability. Kong (2019) discusses the many injustices, competing guiding principles and highly nuanced balances that arise in this context.

Minors

Minors also deserve specific consideration. The general shift from substitute to supported decision-making is more ambiguous and complex in minors, in respect of whom greater degrees of substitute decision-making still occur. When dealing with adults, the guiding principle is the ‘rights, will and preference’ of the individual, but when dealing with minors the CRPD states that the ‘best interests’ of the child shall be paramount (Articles 7 and 23).

Article 7 of the CRPD gives children with disabilities ‘the right to express their views freely on all matters affecting them, their views being given due weight in accordance with their age and maturity, on an equal basis with other children, and to be provided with disability and age-appropriate assistance to realize that right.’ Children and adolescents have demonstrated high levels of decision-making capacity from the age of 12 years, suggesting that additional weight should be given to their preferences at younger ages than is currently common practice (Hein et al, 2015).

The final general principle in Article 3 of the CRPD is ‘respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.’ This highlights the need to include minors in the decision-making process. Assent to treatment should be sought and, where this is not given, a clear rationale provided for clinical decisions. Katz et al (2016) provide a comprehensive discussion of this topic in a medical context. The presence of mental health difficulties adds an additional layer of complexity. Preferences have to be balanced with the views of parents, guardians and professionals, and considered in the context of the child’s capacity and local legislation.

Conclusion

The WHO QualityRights initiative and CRPD provide valuable guidance on protecting the rights of persons with mental illness. They promote the realisation of increased autonomy and choice for individuals with mental illness and offer protection from coercion and exploitation. Healthcare providers have a key role to play in building and promoting the decision-making capacity of individuals attending services, thus optimising care. Mental capacity is a dynamic, decision-specific concept, so, even in jurisdictions that do not conceptualise it in this way, efforts should be continually made to enhance capacity through both formal and informal supports.

Individuals who have experienced coercive practices or who are likely to have episodes of severe illness should be encouraged to take practical steps to plan for future episodes of illness in order to maximise their future autonomy. These practical steps might include

making advance directives, nominating individuals who can support their decision-making and undertaking educational activities that will promote self-advocacy and insight and reduce risk of relapse. Substitute decision-making should be replaced with supported decision-making wherever possible, and an individual's rights, will and preference should be the guiding principles. Individuals should not be prohibited from making decisions simply because others perceive them as unwise.

There is currently no coherent, implementable framework for the complete abolition of all involuntary treatment. Situations may arise that necessitate coercive measures and where this occurs it is vital that procedures are in place to protect the rights of individuals receiving treatment. These include a right to appeal decisions, an automatic review process and free legal representation.

Legislation is an inherent part of psychiatry. Consequently, it is vital that we advocate for positive change in legislation that promotes individual autonomy and ensures access to treatment for individuals with mental illness. It is unacceptable and unjust that individuals can have no entitlement to treatment for mild symptoms of mental illness, but can be treated against their will when symptoms reach a certain threshold. If involuntary treatment is permitted within a jurisdiction, it is vital that there is also a right to voluntary mental healthcare.

Conflict of Interest

None

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“Optimising Patient Care in Psychiatry with Sound Mental Health Legislation”

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Abstract

Mental health law forms a vital component of mental healthcare. Different jurisdictions have different approaches to the extent and nature of legislation in this area. In some jurisdictions, such as Ireland, mental health legislation focuses on areas of traditional concern in mental health law, chiefly, treatment without consent and assuring standards in mental health facilities. In other jurisdictions, such as India, mental health legislation addresses these areas but also seeks to ensure equitable access to services, enhanced social care for the mentally ill, supports for families, and the protection and promotion of a broad range of rights. The World Health Organization and United Nations provide strong support for this more expansive vision of the role of law in protecting the right to health. It is important, however, that the approach in each jurisdiction takes account of the different histories, traditions and pre-existing structures in each country, as well as the specific needs of their populations. Ultimately, optimising patient care and protecting rights are the twin goals of all mental health legislation, which needs to form an embedded part of health and social services in each individual country if it is to achieve its goals. One size does not fit all.

Introduction

Mental health law forms a key component of mental health care in virtually every country in the world. Different jurisdictions have, however, developed different approaches to the purpose, nature, extent and implementation of legislation in this area. This chapter examines two of these different approaches using Ireland and India as examples, and relates legislation in these countries to the positions outlined by the World Health Organisation (WHO) and United Nations (UN). The purpose of these comparisons is to highlight key issues shaping approaches to mental health legislation as a central element of mental health care in different countries around the world. The final section of the chapter presents conclusions and suggested directions for future work in this field.

To begin, it is necessary to pose some fundamental questions about the purpose of mental health legislation in the first place. Why does mental health legislation exist? Is it necessary? Could mental health services function without legislation? Why does mental health legislation continue to exist despite clear evidence of the misuse of such legislation in the past? Can mental health legislation be adapted to the societies and human rights standards of the twenty-first century? If so, how?

The first reason for the persistence of mental health legislation is an historical one. In virtually all countries for which there is recorded history, there has been long-standing recognition of both the existence of mental illness and the need for treatment (Scull, 1993). While certain aspects of societal responses to the mentally ill have varied between jurisdictions, recent centuries have seen clear evidence of both the emergence of community based mental health care and continued provision for the involuntary treatment of a minority of people with severe mental disorders who pose a significant risk to themselves or others (Scull, 2015).

As a result of these developments, mental health legislation was introduced in order to govern such practices in a more accountable way and move involuntary care out of the private sphere, often in private homes and unregulated facilities during the nineteenth century, and into the public sphere, starting initially with government-operated asylums with inspection systems. These developments were at their most intense during the nineteenth century which saw the establishment of large networks of mental hospitals across many countries (Shorter, 1997). For the most part, these institutions went into decline during the latter part of the twentieth century as ideas about “community care” became more prominent.

Despite these changes, treatment without consent has continued and there is, as a result, a continued need for laws to govern it.

The second reason for the existence of mental health legislation is that the evolution of mental health care along the lines outlined above led to a clear need to protect the rights of the mentally ill, especially when they were confined in institutions (Kelly, 2016a). In other words, just as it was deemed important to provide care without consent to the seriously mentally ill, it was soon recognised as equally important that the mentally ill did not experience disproportionate denial of rights while such care was being provided.

Today, it is clear that mental health legislation still serves a number of key purposes. These include not only the provision of care to people who are unable to provide consent and the protection of such persons from unjustified denial of rights during care, but also the need to achieve social justice for the mentally ill more broadly (Gostin et al, 2010). This third reason for existence of mental health law – achieving social justice - reflects a more expansive view of the role of mental health legislation and often involves such laws reaching into new and unfamiliar areas, such as social care, housing policy, general health services and politics more broadly.

Today, there is still a clear and urgent need to reach into these areas in order to achieve meaningful justice for the mentally ill. People with mental illness, especially those with enduring illnesses such as schizophrenia, are at increased risk of poor access to healthcare, homelessness, imprisonment and social exclusion (Kelly, 2005). The negative effects of these social, economic and societal factors, along with the social stigma of mental illness, constitute a form of “structural violence” that amplifies the effects of mental illness in the lives of sufferers. As a result of these over-arching social and economic factors, many people with severe mental illness are systematically excluded from full participation in civic and social life, and are constrained to live lives that are shaped, in large part, by stigma, isolation, homelessness and denial of rights. This is a global scandal.

Addressing these gross inequities and injustices requires a careful combination of psychiatric care, general health services, social support, reform of the criminal justice system, economic assistance, family support and political empowerment of the mentally ill and their families. There is a clear role for mental health legislation in this process, combatting the discrimination and social injustice still experienced by the mentally ill around the world (Callard et al, 2012). More broadly, the WHO (2017) argues that there is a substantial and compelling role for law in achieving the “right to health” for all, not just people with mental

illness (Wolff, 2012). Clearly, achieving these rights for the mentally ill is particularly important, now more than ever.

Against this background, this chapter looks at two different approaches to mental health legislation in order to identify lessons about how such legislation can best help optimise patient care and achieve meaningful justice for the mentally ill. More specifically, this chapter uses two contrasting examples of mental health law in order to explore this topic. The first example is Ireland, which is a typical example of a jurisdiction in which mental health legislation focuses almost exclusively on two areas of traditional concern in mental health law: regulations governing treatment without consent and ways to ensure that high standards are maintained in mental health facilities. This traditional approach to mental health law is also seen in New Zealand's Mental Health (Compulsory Assessment and Treatment) Act, 1992 and England and Wales's Mental Health Act, 1983 (amended in 2007).

The second example is India, where new mental health legislation addresses the same areas as Ireland's legislation, but also seeks to ensure equitable access to services, enhanced social care for the mentally ill, supports for families, and the protection and promotion of a broader range of rights. Other countries have enacted similar legislation in recent years; e.g. Ghana's Mental Health Act, 2012 and Peru's Mental Health Law 29889.

This chapter compares Ireland's rather narrow, focused approach with the much broader approach of India, relates the legislation in these two countries to the views of the WHO and UN, and, in the final section, presents conclusions and suggests directions for future work.

Mental health legislation focused on traditional themes: Ireland

Ireland's Mental Health Act, 2001 was fully implemented in November 2006. The legislation aims, in its own words, "to provide for the involuntary admission to approved centres of persons suffering from mental disorders, to provide for the independent review of the involuntary admission of such persons and, for those purposes, to provide for the establishment of a Mental Health Commission and the appointment of Mental Health Commission Tribunals and an Inspector of Mental Health Services" (Preamble).

From the outset, then, the clear, stated purpose of the Irish legislation is to govern involuntary mental health care and create an updated inspection system for mental health facilities (Kelly, 2016b). In relation to the former, the legislation states that "a person may be involuntarily admitted to an approved centre...on the grounds that he or she is suffering from

a mental disorder” (Section 8(1)), but not “by reason only of the fact that the person (a) is suffering from a personality disorder, (b) is socially deviant, or (c) is addicted to drugs or intoxicants” (Section 8(2)).

“Mental disorder” is defined in the legislation as “mental illness, severe dementia or significant intellectual disability where (a) because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons, or (b) (i) because of the severity of the illness, disability or dementia, the judgment of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission, and (ii) the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit or alleviate the condition of that person to a material extent” (Section 3(1)). More detailed definitions are provided for the terms “mental illness”, “severe dementia” and “significant intellectual disability” (Section 3(2)).

The 2001 Act outlines a three-step involuntary admission process that involves (a) an “application” for involuntary admission (e.g. by a family member or police officer); (b) a “recommendation” made by a general practitioner or other doctor; and (c) an “admission order” made by a consultant psychiatrist in an “approved centre” (inpatient psychiatry unit). The involuntary patient receives free legal aid and a free independent psychiatric examination. The involuntary admission order or renewal order is subject to review by an independent Mental Health Tribunal within 21 days of the order being made.

There is a different process for the involuntary retention of a person who already is a voluntary inpatient in a psychiatry unit but expresses a desire to leave. If such a person fulfils criteria for “mental disorder” (Section 3(1)), they can be retained in the inpatient facility by a nurse or doctor for up to 24 hours. Within this period, the patient is assessed by two consultant psychiatrists and a decision is made about whether or not the patient’s status should be changed from voluntary to involuntary. Such a decision is also subject to review by a Mental Health Tribunal within 21 days of the involuntary order being made.

Ireland’s Mental Health Act, 2001 also deals with other areas of involuntary treatment. It makes provisions for the administration of medication (Section 60), electro-convulsive therapy (ECT) (Section 59) and seclusion and restraint (Section 69).

This, then, is the first focus of Ireland’s mental health legislation: regulating involuntary care and reviews of involuntary admission decisions by Mental Health Tribunals.

The second focus of the legislation is the creation and maintenance of a new and updated system of inspection for mental health facilities. The 2001 Act specifies that the principal functions of Ireland's "Inspector of Mental Health Services" are "to visit and inspect every approved centre at least once in each year" and "to visit and inspect any other premises where mental health services are being provided as he or she thinks appropriate" (Section 51(1)). The Inspector writes an annual report which is published each year on the website of the Mental Health Commission (www.mhcirl.ie).

In these two areas – involuntary care and assuring standards of care – Ireland's mental health legislation meets the great majority of relevant human rights standards outlined by the WHO in its *Resource Book on Mental Health, Human Rights and Legislation* (WHO, 2005). Areas of low compliance with these standards relate to promoting rights (which impacts on other areas within the legislation, such as information management), treatment of voluntary patients (especially non-protesting, incapacitated patients), the protection of vulnerable groups and emergency treatment (Kelly, 2011). The WHO *Resource Book* also emphasizes the protection of social rights, such as rights to housing, employment and social security. These are not considered under 'mental health law' in Ireland. While protections from discrimination exist in these areas, people with mental illness do not get the level of consideration that their specific needs require.

The reason why the Irish legislation does not score highly in some of these areas relates chiefly to the fact that the legislation does not seek to address many of them, opting instead to focus almost exclusively on involuntary care and inspections. The legislation has, for example, very few provisions relating to voluntary patients. It defines a "voluntary patient" as "a person receiving care and treatment in an approved centre who is not the subject of an admission order or a renewal order" (Section 2(1)), but it provides very little further information about the management of voluntary patients or any other issues pertaining to them.

This is not necessarily a flaw in the legislative provisions of the 2001 Act, but, rather, a reflection of the limited scope of the legislation, which is strongly focused on regulating involuntary care and the functions of the Inspector of Mental Health Services. There is some evidence that this rather narrow focus is useful: Ireland now has a highly functional system of Mental Health Tribunals to protect patients' rights and Ireland's rate of involuntary care is low by international standards, being less than half of the rate in neighbouring England (Gilhooley and Kelly, 2018).

There are, however, also significant limitations with this focused approach, with the result that the Irish legislation does not meet WHO requirements in many important areas, chiefly relating to broader protections of rights (Kelly, 2011). As a result, some of the key areas in need of attention in Ireland's mental health legislation include measures to protect and promote the rights of voluntary patients, issues relating to competence, capacity and consent (which will be partly addressed in the new Assisted Decision-Making (Capacity) Act, 2015); and the extent to which Ireland wishes to protect the economic and social rights of the mentally ill through mental health legislation rather than general legislation or social policy.

These matters are currently unresolved in Ireland. In seeking to address them, Irish legislators could usefully look to recent developments in India for possible lessons about a more ambitious, extended view of the role of mental legislation in protecting and promoting the rights of the mentally ill and their families.

Mental health legislation focused on broader themes: India

On 29 May 2018, new mental health legislation was commenced in India, titled the Mental Healthcare Act, 2017. The new legislation sought explicitly to comply with the UN Convention on the Rights of Persons with Disabilities (CRPD) (UN, 2006) and therefore covered both (a) areas traditionally addressed in mental health legislation, such as treatment without consent and oversight of standards, and (b) the broader areas that are often neglected in such laws, such as broader protections of rights. India's legislation is undoubtedly the most interesting and potentially educational development in mental health law in several decades, and it merits close attention as a result.

In the first instance, India's new Act, like similar legislation in other jurisdictions, includes new definitions of certain key terms (such as "mental illness" and "mental health establishment"); an updated consideration of "capacity" in relation to mental healthcare; "advance directives" to permit people with mental illness to direct future care; changes in the roles of family and "nominated representatives" (who need not be family members); revised procedures for admission (both with and without patient consent); new "Mental Health Review Boards" to review admissions and other matters; new rules governing treatment, restraint and research; and the establishment of various governmental authorities to oversee services (Duffy and Kelly, 2019). There is also *de facto* decriminalization of suicide, which has been widely welcomed.

Most dramatically, however, the new Indian legislation steps well beyond the confines of traditional mental health law and grants a legally binding right to mental healthcare to the entire population of India. This is a very expansive right impacting on many aspects of the lives and experiences of people with mental illness and their families. The granting of this right is a notably dramatic development for mental health law in India or, indeed, anywhere.

More specifically, India's 2017 Act states that "every person shall have a right to access mental healthcare and treatment from mental health services run or funded by the appropriate Government" (Section 18(1)). The legislation goes on to specify the inclusive nature of this right:

"The right to access mental healthcare and treatment shall mean mental health services of affordable cost, of good quality, available in sufficient quantity, accessible geographically, without discrimination on the basis of gender, sex, sexual orientation, religion, culture, caste, social or political beliefs, class, disability or any other basis and provided in a manner that is acceptable to persons with mental illness and their families and care-givers" (Section 18(2)).

As a result of this provision, all of the 1.3 billion people in India, amounting to one sixth of the planet's population, have been granted a fully justiciable, legal right to mental healthcare. The legislation is quite specific about what this involves, stating that "the appropriate Government shall make sufficient provision as may be necessary, for a range of services required by persons with mental illness" (Section 18(3)), including:

- (a) Provision of acute mental healthcare services such as outpatient and inpatient services;
- (b) Provision of half-way homes, sheltered accommodation, supported accommodation as may be prescribed;
- (c) Provision for mental health services to support family of person with mental illness or home-based rehabilitation;
- (d) Hospital and community-based rehabilitation establishments and services as may be prescribed;
- (e) Provision for child mental health services and old age mental health services (Section 18(4)).

This provision of a right to mental healthcare overcomes a highly problematic and common injustice. Jurisdictions that allow involuntary treatment without providing a right to mental healthcare can facilitate individuals oscillating between being “well and untreated” and being “unwell and treated involuntarily”. An individual’s mental health might be in decline, but they might have no way of accessing care until they reach the threshold for involuntary treatment. Often this occurs when they present a risk to themselves or others. As a result, a right to *voluntary* treatment for mental health conditions is vital to optimising mental healthcare.

Using mental health legislation to grant rights in this way is broadly consistent with the approaches of both the UN CRPD (UN, 2006) and the *WHO Resource Book on Mental Health, Human Rights and Legislation* (WHO, 2005). As a result, India’s new Act meets 96 (55%) of the 175 relevant WHO human rights standards (Duffy and Kelly, 2017). When other relevant Indian legislation is taken into account, some 118 (67%) of the WHO standards are now addressed in Indian law - an outcome that compares very favourably with many other jurisdictions (Kelly, 2011).

Despite the clear vision and ambition of India’s approach, however, there are significant issues which still need to be resolved with the legislation. The first issue is that there are still some important areas of low concordance with WHO standards, relating chiefly to the rights of families and carers, competence and guardianship, non-protesting patients and involuntary treatment in the community. These areas require further attention, possibly in regulations or further rules. In addition, certain provisions, such as the Act’s ban on ECT without muscle relaxants and anaesthesia, have proven controversial among psychiatrists in India (Andrade et al, 2012; Duffy et al, 2019). It is to be hoped that these issues can be resolved during the course of implementation across the country.

The second issue with India’s new legislation is, perhaps, more fundamental, and it concerns whether or not the rights outlined in the new Indian legislation can truly be achieved in practice. Even prior to this legislation, it was clear that Indian mental health services are significantly under-resourced. In 2016, the *National Mental Health Survey of India, 2015-16* reported a “treatment gap” of approximately 85% for common mental disorders and 74% for severe mental disorders, including such conditions as psychosis (75%) and bipolar affective disorder (70%) (Gururaj et al, 2016).

This situation is largely attributable to the facts that less than 1% of the Indian health budget is allocated to mental healthcare (Patel et al, 2016) and there is a long-standing shortage of human resources (Jiloha, 2015). India has just 0.3 psychiatrists per 100,000

population, compared to 2.2 in China and 10.5 in the United States of America (WHO, 2019). There is a similar paucity of nurses, with just 0.8 mental health nurses per 100,000 people in India compared to 5.4 in China and 4.3 in the US. These are profound resource problems that will be difficult to remedy quickly, even though India's new legislation clearly requires steps to be taken in this direction as a matter of urgency.

Against this background, it is clear that closing the treatment gaps in India's mental health services presents a substantial challenge to full implementation of the new legislation, even before the Act's additional rights, such as rights to accommodation, can be achieved. Other key challenges with the new legislation include resourcing the new structures outlined in the Act, the appropriateness of apparently increasingly legalized approaches to care (especially the consequences of potentially lengthy judicial proceedings) and the possible negative effects of specific aspects of the legislation that could result in barriers to care (e.g. revised licensing requirements for general hospital psychiatry units) (Duffy and Kelly, 2019).

Notwithstanding these challenges, India's new legislation clearly offers substantial potential benefits to India and, by example, to other countries that wish to align their mental health laws with the CRPD. At the same time, however, India's 2017 Act also stands in stark contrast with more traditional mental health legislation, such as that in Ireland, which does not grant legally binding rights to mental health care and is far more circumspect in its ambitions.

Interestingly, both India and Ireland have stopped short of embracing some of the most recent guiding principles proposed for mental health legislation. One interpretation of the CRPD, for example, proposes removing all involuntary treatment from mental healthcare. These ideas have been most clearly articulated by the UN Committee on the Rights of Persons with Disabilities (2014) and the WHO's QualityRights initiative (WHO, 2012). This emphasis on a particular interpretation of autonomy as the key ethical principle in mental healthcare has proven controversial, on the basis that it might, paradoxically, curtail certain rights of persons with mental illness (Appelbaum, 2019; Raveesh et al, 2019).

Such dramatic proposals for reform of mental health legislation pose many difficult questions that currently remain unanswered. While the pragmatic realisation of entirely voluntary mental healthcare is still being debated, however, India appears to have struck a difficult balance by enacting broad-based mental health law that seeks to provide greater autonomy to patients and provide care to all. Its Mental Healthcare Act, 2017 includes many of the elements of traditional legislation, but attempts to minimise conceive practices and facilitate individual choice were possible.

The final section of this chapter examines the extent to which each of these different approaches in Ireland and India effectively use mental health legislation to help optimise patient care.

Conclusions

Mental health legislation forms an important element of patient care in psychiatry. Regardless of the contrasting approaches in countries such as Ireland and India, virtually all jurisdictions recognise a need for dedicated mental health legislation that both facilitates delivery of care to people who lack the decision-making capacity to consent and helps protect and promote the rights of the mentally ill and their families.

There are, however, undeniable differences between jurisdictions. In Ireland, as we have seen, mental health legislation focuses on areas of traditional concern in mental health law, chiefly, treatment without consent and assuring standards in mental health facilities. This is a very narrow, focused vision of the role of mental health law.

In other jurisdictions, such as India, mental health legislation addresses these areas of traditional concern, but also seeks to ensure equitable access to services, enhanced social care for the mentally ill, supports for families, and the protection and promotion of a broader range of rights. This is an approach that is explicitly informed by the UN CRPD, which was not published when Ireland's Mental Health Act, 2001 was developed.

In broad terms, both the WHO and UN provide strong support for India's more expansive vision of the role of law in protecting the right to mental health. This is, perhaps, a more modern approach to mental health legislation, compared to Ireland, and it is an approach that is likely to gain traction in other countries, following the ambitious example set by India's legislators.

It is important, however, that the approach to mental health legislation in any jurisdiction takes careful account of the history, traditions and pre-existing legislative structures in that jurisdiction, as well as the specific needs of the population in question. One size does not fit all. In the case of India, while many aspects of the 2017 Act have been welcomed, important questions have been raised about the extent to which rights-based legislation can achieve its stated goals.

Raveesh and colleagues (2019), for example, note that the UN CRPD is a major milestone but also note, among other observations, that the concept of vulnerability is not addressed; that mental illness is not necessarily associated with disability; that empirical

research on certain aspects of the UN CRPD is scarce; and that more evidence is needed in this area. They also note that the UN CRPD has the potential to undermine certain rights if, for example, the insanity defense was to be abolished. In addition, rights are not always the only, or even the best, way to distribute scarce resources or meet all human needs; other methods include political (rather than judicial) allocation of public resources, myriad forms of exchange, community relations, charitable activities and various other local arrangements (Osiatyński, 2009).

These compelling arguments point to some of the potential limitations of relying exclusively or even very heavily on the UN CRPD in shaping approaches to mental health legislation. Clearly there is a balance to be reached between the narrow focus of legislation in countries such as Ireland and the expansive ambition displayed in India's 2017 Act. While it is important that legislation has ambition and vision, it is also important that legislation works on the ground, that at least some of its goals are achievable, and that ideas about human rights do not inadvertently result in legislation becoming irrelevant, stakeholders becoming disenchanted and patients being paradoxically neglected as a result of legislation intended to assist them.

India's ambitious step forward into rights-based mental health law merits close attention over the years to come. Future research could usefully examine the extent of implementation across the country, the benefits of the new legislation, any paradoxical negative effects, and any lessons that are potentially transferrable to other jurisdictions. The new Indian legislation presents a once-in-a-generation opportunity to gain an understanding of the extent to which such legislation can truly impact on mental health services and improve the position of the mentally ill and their families.

Ultimately, optimising patient care and protecting rights are the twin goals of all mental health legislation, which needs to form an embedded part of health and social services if it is to achieve its goals. The optimal approach probably lies somewhere between the approach in Ireland and that in India, but further work is needed to identify precisely what that optimal approach involves.

Conflict of Interest

None

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