Original Article

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	FG 2	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."
Unmodified ECT (i.e., without anesthetic)		"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."
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 toECT

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."
	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."
Non- medical models of mental health	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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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

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