INTERNATIONAL JOURNAL OF HUMAN RIGHTS LAW REVIEW
An International Open Access Double Blind Peer Reviewed, Referred Journal

Volume 5 | Issue 6 | 2026 Art. 20

Supported Decision-Making under the Mental Healthcare Act, 2017 and Article 12 of the Convention on the Rights of Persons with Disabilities

Sowndariya S
Assistant Professor,
School of Law,
Vel Tech Rangarajan Dr. Sagunthala R&D Institute of Science and Technology, Chennai

Recommended Citation
Sowndariya S, *Supported Decision-Making under the Mental Healthcare Act, 2017 and Article 12 of the Convention on the Rights of Persons with Disabilities*, 5 IJHRLR 243-255 (2026).
Available at www.ijhrlr.in/current-issues/.

This Article is brought to you for free and open access by the International Journal of Human Rights Law Review by an authorized Lex Assisto & Co. administrator.
For more information,
please contact submission.ijhrlr@gmail.com

Supported Decision-Making under the Mental Healthcare Act, 2017 and Article 12 of the Convention on the Rights of Persons with Disabilities

ABSTRACT

India's ratification of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) on 1 October 2007 pushed Indian law away from custodial mental health legislation and towards a rights-based framework. Enacted partly to give effect to those obligations, the Mental Healthcare Act, 2017 (MHCA 2017) introduces a presumption of decisional capacity (section 4), advance directives (sections 5–13) and nominated representatives (sections 14–17). The UN Committee on the Rights of Persons with Disabilities (CRPD Committee), however, reads Article 12 in General Comment No 1 (2014) as demanding universal legal capacity and the abolition of all substitute decision-making. This paper asks whether the MHCA 2017 delivers genuine, supported decision-making or keeps a form of substitute decision-making alive through its capacity provisions, its supported admission regime (sections 89–90) and the 'best interests' language in section 17. It draws on Indian scholarship, the Act's interaction with guardianship laws and Supreme Court decisions, including Common Cause, Ravinder Kumar Dhariwal and Gaurav Kumar Bansal, and proposes statutory and institutional reforms to narrow the gap between the Act and Article 12.

KEYWORDS

Mental Healthcare Act, 2017, UNCRPD, Supported Decision-Making, Advance Directives, Legal Capacity.

1. INTRODUCTION: THE UNCRPD PARADIGM SHIFT AND INDIA'S STATUTORY REFORM

For roughly a century, Indian mental health law followed a custodial model, first under the Indian Lunacy Act, 1912 and then under the Mental Health Act, 1987. Both put institutional confinement and medical judgment ahead of the patient's own agency.[1] India ratified the UNCRPD on 1 October 2007, and the ratification moved the law away from the

[1] Richard M Duffy and Brendan D Kelly, 'India's Mental Healthcare Act, 2017: Content, Context, Controversy' (2019) 62 International Journal of Law and Psychiatry 169; Mental Healthcare Act, 2017 (Act 10 of 2017) (MHCA 2017) s 126 (repealing the Mental Health Act, 1987).

'medical model' of disability towards a human-rights and social model.[2] Parliament then passed the Rights of Persons with Disabilities Act, 2016 and the Mental Healthcare Act, 2017 (MHCA 2017). The MHCA 2017 states in its preamble that its purpose includes aligning and harmonising existing law with the Convention,[3] and it makes India one of the more ambitious Global South jurisdictions to attempt a statutory form of supported decision-making.

Yet a wide gap remains between the MHCA 2017 and the strict reading of Article 12 put forward by the CRPD Committee. A look at capacity assessment, advance directives and nominated representatives shows an Act that, in both text and clinical practice, sits somewhere between supported and substituted decision-making.

1.1 Research Questions and Methodology:

This paper examines four questions: (i) what legal standard does Article 12 of the UNCRPD, as interpreted by the CRPD Committee in General Comment No 1, establish for legal capacity and supported decision-making; (ii) how does section 4 of the Mental Healthcare Act, 2017 operationalize decisional capacity; (iii) to what extent do advance directives (sections 5–13) and nominated representatives (sections 14–17) replace or preserve substitute decision-making; and (iv) what judicial and institutional bottlenecks impede implementation in India? The study adopts a doctrinal and comparative methodology, analysing the UNCRPD, General Comment No 1, the MHCA 2017, allied Indian guardianship statutes, Supreme Court jurisprudence and empirical clinical literature from India.

2. ARTICLE 12 OF THE UNCRPD AND THE CRPD COMMITTEE'S GENERAL COMMENT NO. 1

Article 12 of the UNCRPD guarantees that persons with disabilities 'enjoy legal capacity on an equal basis with others in all aspects of life' (Article 12(2)). States Parties must 'take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity' (Article 12(3)), with safeguards that respect the 'rights, will and preferences' of the person (Article 12(4)).[4] In General Comment No 1 (2014), the CRPD Committee separates 'legal capacity', the universal right to hold rights and to act on them, from

[2] Convention on the Rights of Persons with Disabilities (adopted 13 December 2006, entered into force 3 May 2008) 2515 UNTS 3 (UNCRPD); MHCA 2017 (n 1) preamble (recording India's ratification on 1 October 2007).
[3] MHCA 2017 (n 1) preamble.
[4] UNCRPD (n 2) art 12(2)-(4).

'mental capacity', which refers to a person's decision-making skills.[5]

General Comment No 1 rejects 'status', 'outcome' and 'functional' approaches to capacity alike, because each denies legal capacity based on a perceived cognitive deficit. In the Committee's words, 'perceived or actual deficits in mental capacity must not be used as justification for denying legal capacity'.[6] The Committee also says that States must abolish substitute decision-making regimes, including plenary and partial guardianship and forced psychiatric treatment, and must do so immediately rather than progressively, replacing 'best interests' determinations with the 'best interpretation of will and preferences'.[7] Some scholars regard this absolutist position as unworkable in acute psychiatric crises and in cases of severe dementia.[8] The Committee nonetheless treats it as the correct reading of Article 12, and the 2023 WHO and OHCHR guidance on mental health legislation likewise builds on the Convention's rights-based approach.[9] General Comments are not legally binding treaties in themselves, nor do they create independent causes of action; rather, they constitute authoritative, soft-law interpretations by the treaty-monitoring body under Article 34 of the UNCRPD. Their persuasive value lies in guiding domestic courts and legislatures on good-faith treaty compliance under international law, even where States retain margin-of-appreciation debates over acute psychiatric emergencies.

In its Concluding Observations on India's initial report in October 2019, the CRPD Committee expressed concern that Indian law continues to permit substitute decision-making and guardianship regimes—across the Guardians and Wards Act, 1890, the National Trust Act, 1999, the Rights of Persons with Disabilities Act, 2016 and the MHCA 2017—urging India to repeal provisions allowing deprivation of legal capacity and to establish comprehensive supported decision-making mechanisms.[10]

---

[5] CRPD Committee, 'General Comment No 1 (2014): Article 12: Equal Recognition before the Law' (19 May 2014) UN Doc CRPD/C/GC/1 (GC 1) paras 12–13.
[6] GC 1 (n 5) paras 13, 15.
[7] GC 1 (n 5) paras 21, 27–30, 42.
[8] Gerald L Neuman, 'Divergent Human Rights Approaches to Capacity and Consent' in Michael Ashley Stein and others (eds), *Mental Health, Legal Capacity, and Human Rights* (CUP 2021).
[9] World Health Organization and Office of the United Nations High Commissioner for Human Rights, *Mental Health, Human Rights and Legislation: Guidance and Practice* (2023) <https://www.ohchr.org/sites/default/files/documents/publications/WHO-OHCHR-Mental-health-human-rights-and-legislation_web.pdf>.
[10] CRPD Committee, 'Concluding Observations on the Initial Report of India' (29 October 2019) UN Doc CRPD/C/IND/CO/1.

3. DECISIONAL CAPACITY UNDER SECTION 4 OF THE MENTAL HEALTHCARE ACT, 2017

Section 4 is the statutory centre of the Act. It presumes that every person, including a person with mental illness, has capacity to make decisions about mental healthcare or treatment.[11] Under section 4(1) a person is deemed to have capacity if able to (a) understand the information relevant to a decision on treatment, admission or personal assistance, (b) appreciate any reasonably foreseeable consequence of a decision or lack of decision, or (c) communicate the decision by speech, expression, gesture or any other means. Read literally, the three limbs are alternatives, and the Act does not say how they are to be weighed. Section 4(2) requires the information to be given in simple language or by other suitable means, and section 4(3) provides that a decision others see as inappropriate or wrong does not by itself show a lack of capacity.[12]

In doctrinal terms, section 4 brings mental healthcare into line with the Supreme Court's informed-consent jurisprudence and separates diagnosis from automatic incapacity.[13] From the standpoint of General Comment No 1, though, it is still a functional capacity test. Capacity is assessed by clinicians, and section 81 requires the Central Authority to have an Expert Committee prepare a guidance document that assessors must follow.[14] A person who is 'unable to make mental healthcare and treatment decisions independently' and needs 'very high support' from a nominated representative cannot be treated as an independent patient (sections 85–86) and may instead be admitted as a supported patient on the representative's application (sections 89–90).[15] Where such a person needs nearly 100 per cent support, the nominated representative may temporarily give consent to treatment (section 89(7)).[16] This is a capacity-based threshold that removes the person's own consent, and it is the point at which the Act most clearly keeps substitute decision-making.

Two doctrinal tensions arise here. First, while section 4 equates capacity with cognitive-functional performance at a specific moment in time (decisional capacity), Article 12, as interpreted in General Comment No 1, treats legal capacity as an inherent attribute of personhood that persists regardless of fluctuations in mental capacity. By making independent consent contingent on passing section 4(1), the MHCA 2017 preserves a gatekeeping threshold that General Comment No 1 seeks to dismantle. Secondly, section 89(7)'s temporary grant of treatment-consent power to

[11] MHCA 2017 (n 1) s 4(1).
[12] MHCA 2017 (n 1) s 4(2)–(3).
[13] See eg Samira Kohli v Dr Prabha Manchanda (2008) 2 SCC 1.
[14] MHCA 2017 (n 1) s 81.
[15] MHCA 2017 (n 1) ss 85–86, 89(1)(c) and 90.
[16] MHCA 2017 (n 1) s 89(7).

a nominated representative, where a patient requires nearly 100 per cent support, raises a serious question under Article 12. Even though this power is time-bound and subject to Board oversight, it may permit the representative's consent to operate in place of the patient's own consent. To that extent, the provision resembles a regulated form of substitute decision-making rather than a system based exclusively on supported decision-making. Its compatibility with Article 12 therefore depends on whether the patient's will and preferences remain central to the decision and whether the statutory safeguards operate effectively in practice.

4. ADVANCE DIRECTIVES AND NOMINATED REPRESENTATIVES: SUPPORTED OR SUBSTITUTED?

4.1 Psychiatric Advance Directives (Sections 5–13)

Sections 5 to 13 let every adult, including a person with a past mental illness, make a written advance directive (AD). The AD can say how the person wishes to be cared for and treated, how the person does not wish to be cared for and treated, and whom the person appoints as nominated representative (NR).[17] An AD is made in the manner the regulations specify (section 6), and each Mental Health Review Board (MHRB) keeps an online register of the ADs registered with it (section 7).[18] A valid AD binds the treating psychiatrist and the medical officer in charge of a mental health establishment, subject to the Board's power to review, alter, modify or cancel it on application (sections 10, 11 and 82(1)(a)).[19] It does not apply to emergency treatment (section 9, read with section 94).[20]

Despite this progressive design, three limitations weaken ADs in practice. First, the Act does not recognise 'Ulysses clauses', the self-binding directives accepted in some jurisdictions. An AD operates only while the person lacks capacity, a decision made with capacity overrides any earlier AD, and the person may revoke, amend or cancel it at any time (sections 5(3)–(4) and 8). That leaves unresolved the tension between what a person competently decided in advance and what the same person wants in a crisis.[21] Second, the Act does not oblige clinicians or anyone else to help a person draft an AD, which makes a valid directive hard to produce without assistance.[22] Empirical studies conducted in Tamil Nadu and Karnataka underscore this gap between

[17] MHCA 2017 (n 1) s 5(1)–(2).
[18] MHCA 2017 (n 1) ss 6–7.
[19] MHCA 2017 (n 1) ss 10–11, 82(1)(a).
[20] MHCA 2017 (n 1) ss 9, 94. Section 9 refers to emergency treatment 'under section 103', which appears to be a numbering slip for section 94.
[21] MHCA 2017 (n 1) ss 5(3)–(4), 8(1).
[22] See Sharad Philip and others, 'Advance Directives and Nominated Representatives: A Critique' (2019) 61 Indian Journal of Psychiatry S680.

statutory design and clinical reality. In a multi-site outpatient study, all 93 participants assessed as having capacity wrote valid advance directives, over 65 per cent independently, 29 per cent with prompts and 6 per cent with scribes and none used them for blanket refusal of treatment.[23]Similarly, an inpatient study at the National Institute of Mental Health and Neuro Sciences (NIMHANS) found that 96 per cent of nearly 200 pre-discharge inpatients formulated advance directives and 94 per cent appointed a nominated representative, predominantly a family member.[24]Yet another NIMHANS outpatient study found that 93 of 100 participants required both reminding and writing assistance, while qualitative research from Tamil Nadu documented widespread caregiver skepticism regarding patients' decisional capacity.[25] These empirical findings suggest three practical realities. First, the fact that none of the outpatients in the multi-site study used advance directives for blanket refusal of treatment provides evidence against the concern that advance directives necessarily encourage treatment refusal. Rather, the findings indicate that participants were able to preserve access to ongoing care while expressing preferences regarding specific interventions. Although the sample size limits the generalisability of this finding, it demonstrates the potential of advance directives to promote patient autonomy without necessarily discouraging treatment. Secondly, because over 90 per cent of outpatients in the NIMHANS study needed prompting or writing assistance, accessibility, not patient competence is the primary barrier to uptake. Thirdly, caregiver scepticism indicates that without statutory facilitation and family sensitisation, advance directives risk being sidelined in India's family-centred care model. Registration also depends on functioning Mental Health Review Boards under section 7. As the Supreme Court's implementation monitoring in Gaurav Kumar Bansal demonstrates, these Boards remain unevenly constituted and operational across States. These institutional deficiencies risk making advance directives inaccessible to persons with lower literacy or limited clinical support.[26]

4.2 Nominated Representatives (Sections 14–17) and Guardianship

[23] T C Ramesh Kumar and others, 'Psychiatric Advance Statements: An Indian Experience' (2013) 59 International Journal of Social Psychiatry 531.

[24] Guru S Gowda and others, 'Factors Influencing Advance Directives among Psychiatric Inpatients in India' (2018) 56 International Journal of Law and Psychiatry 17.

[25] Philip and others (n 22); Laura S Shields and others, 'Unpacking the Psychiatric Advance Directive in Low-Resource Settings: An Exploratory Qualitative Study in Tamil Nadu, India' (2013) 7 International Journal of Mental Health Systems 29.

[26] Gaurav Kumar Bansal v Union of India WP (C) No 1496 of 2018 (SC, 28 October 2025) (noting the Union's affidavit that Boards had been constituted in various States and Union Territories, with work continuing to make them fully operational).

Friction

Under section 14, any adult may appoint a nominated representative in writing on plain paper, signed or with a thumb impression, and no registration with the MHRB is required. If none is appointed, section 14(4) fixes an order of precedence: the person named in an AD, then a relative, then a care-giver, then a suitable person appointed by the Board, and finally the Director of the Department of Social Welfare.[27] Section 14 also says that appointing an NR, or being unable to appoint one, does not show a lack of capacity, and that all persons with mental illness have capacity to make mental healthcare decisions but may need varying levels of support from their NR (section 14(8)–(9)).[28] Those provisions read like supported decision-making. Section 17 is different. It requires the NR to consider the person's current and past wishes, life history, values and cultural background 'and the best interests' of the person, and to give 'particular credence' to the person's views only 'to the extent that the person understands the nature of the decisions under consideration'.[29] That is a hybrid, and it falls short of the 'will and preferences' standard in General Comment No 1.[30] Indian law on guardianship is also fragmented, spread across the Guardians and Wards Act, 1890, the National Trust Act, 1999 and the limited guardianship provision in section 14 of the Rights of Persons with Disabilities Act, 2016.[31] The table below summarises the alignment and key operational gaps across the MHCA 2017's primary decision-making mechanisms.

Mechanism	**MHCA 2017 Provision**	**Alignment with UNCRPD Art. 12 / GC No. 1**	**Key Operational Gap**
Capacity Test	Section 4 (presumption of capacity; three alternative functional limbs).	Partial: rejects status-based incapacity, but retains functional threshold denied by GC No. 1.	Capacity is assessed by clinicians under the section 81 guidance document; the Board reviews

[27] MHCA 2017 (n 1) s 14(1)–(2), (4).
[28] MHCA 2017 (n 1) s 14(8)–(9).
[29] MHCA 2017 (n 1) s 17(a)–(b).
[30] GC 1 (n 5) para 21.
[31] Guardians and Wards Act, 1890 (Act 8 of 1890); National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999 (Act 44 of 1999) ss 13–14; Rights of Persons with Disabilities Act, 2016 (Act 49 of 2016) s 14.

			only on application (section 82(1)(c)).
Advance Directives	Sections 5–13 (duty to follow, s 10; revocable, s 8; Board review, s 11).	Strong: operationalizes prospective autonomy and 'will and preferences.'	No duty to help with drafting; no Ulysses clause (ss 5(4), 8); registration depends on functioning Boards (s 7).
Nominated Representative	Sections 14–17 (plain-paper appointment; s 14(4) order of precedence).	Hybrid: requires considering wishes, but retains 'best interests' fallback.	Section 17(a) 'best interests' standard; overlap with guardianship laws.
Supported Admission	Sections 89–90 (supported admission up to 30 days, and beyond 30 days).	Divergent: permits non-consensual admission and treatment on NR consent.	Safeguards depend on Boards deciding challenges within 7 days (s 89) or 21 days (s 90) (s 80(2)–(3)); not all Boards are fully operational.

5. JUDICIAL TRAJECTORY AND IMPLEMENTATION BOTTLENECKS IN INDIA

The Supreme Court has strengthened the autonomy-enhancing core of the Act through its Article 21 jurisprudence. In *Common Cause (A Registered Society) v Union of India*, a Constitution Bench held advance medical directives (living wills) on the withdrawal of life-sustaining treatment to be constitutionally valid under Article 21, and the Court

simplified the authentication procedure in January 2023.[32] Although Common Cause supports the constitutional legitimacy of prospective healthcare autonomy under Article 21, two key differences separate constitutional living wills from psychiatric advance directives under the MHCA 2017. First, Common Cause directives govern end-of-life withdrawal of life-sustaining treatment in terminal or irreversible conditions and require judicial/notarial attestation and multi-tier medical board review, whereas MHCA 2017 advance directives govern ongoing mental healthcare and require registration with a Mental Health Review Board. Secondly, unlike end-of-life directives that operate when recovery is not expected, psychiatric advance directives must navigate episodic incapacity where a patient may later regain capacity or express conflicting crisis-period wishes. In *Ravinder Kumar Dhariwal v Union of India*, the Court drew on the MHCA 2017 and the UNCRPD to advance substantive and transformative equality for persons with mental disabilities in public employment.[33]

In practice, though, institutional gaps remain acute. In the long-running proceedings in Gaurav Kumar Bansal, the Supreme Court repeatedly censured State Governments including Maharashtra and Uttar Pradesh for merely re-designating old-age or beggar homes as halfway homes, flagged violations of institutionalised women's dignity and privacy rights under section 20(2) of the Act, and directed the creation of a real-time national dashboard for rehabilitation facilities before transferring implementation monitoring to the National Human Rights Commission on 28 October 2025.[34] Moreover, although sections 19 (right to community living) and 115 (decriminalisation of attempted suicide) reinforce a non-coercive, community-oriented philosophy,[35] their promise depends on operational Mental Health Review Boards and district-level services. Without functioning Boards, digital AD registries and community support networks, such as the 'Circle of Care' model developed by Seher in Pune, supported decision-making is likely to remain largely aspirational.[36]

6. CONCLUSION AND REFORM ROADMAP

The Mental Healthcare Act, 2017 is a landmark step towards the

[32] Common Cause (A Registered Society) v Union of India (2018) 5 SCC 1; MA No 1699 of 2019 (SC, 24 January 2023) (modifying the guidelines).
[33] Ravinder Kumar Dhariwal v Union of India 2021 SCC OnLine SC 1293 (Civil Appeal No 6924 of 2021, decided 17 December 2021).
[34] Gaurav Kumar Bansal v Mr Dinesh Kumar (SC, 1 September 2021); Gaurav Kumar Bansal v Union of India WP (C) No 1496 of 2018 (SC, 28 October 2025).
[35] MHCA 2017 (n 1) ss 19, 20(2), 115.
[36] Bhargavi V Davar, Kavita Pillai and Kimberly LaCroix, 'Seher's "Circle of Care" Model in Advancing Supported Decision Making in India' in Stein and others (n 8).

UNCRPD's vision of equal legal capacity, but it stops short of the CRPD Committee's call to abolish substitute decision-making altogether. Closing the gap needs four reforms. First, section 17(a) should be amended to replace the 'best interests' standard with the 'best interpretation of will and preferences'. Secondly, AD registration should be simplified through an accessible, privacy-protected digital register, and clinicians or other trained persons should be required to help people draft ADs. Thirdly, the MHCA 2017, the Rights of Persons with Disabilities Act, 2016 and the guardianship laws should be harmonised into a single supported decision-making framework. Fourthly, community-based crisis support and functioning Boards should be in place across the country.

BIBLIOGRAPHY

1. Cases

- *Common Cause (A Registered Society) v Union of India* (2018) 5 SCC 1.
- *Gaurav Kumar Bansal v Mr Dinesh Kumar* (Supreme Court, 1 September 2021).
- *Gaurav Kumar Bansal v Union of India* WP (C) No 1496 of 2018 (Supreme Court, 28 October 2025).
- *Ravinder Kumar Dhariwal v Union of India* 2021 SCC OnLine SC 1293.
- *Samira Kohli v Dr Prabha Manchanda* (2008) 2 SCC 1.

2. Indian Legislation

- Guardians and Wards Act, 1890 (Act 8 of 1890).
- Indian Lunacy Act, 1912.
- Mental Health Act, 1987.
- Mental Healthcare Act, 2017 (Act 10 of 2017).
- National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999 (Act 44 of 1999).
- Rights of Persons with Disabilities Act, 2016 (Act 49 of 2016).

3. International Instruments

- Convention on the Rights of Persons with Disabilities (adopted 13 December 2006, entered into force 3 May 2008) 2515 UNTS 3.

4. Official Reports and Materials

- Committee on the Rights of Persons with Disabilities, 'General Comment No 1 (2014): Article 12: Equal Recognition before the Law' (19 May 2014) UN Doc CRPD/C/GC/1.

- Committee on the Rights of Persons with Disabilities, 'Concluding Observations on the Initial Report of India' (29 October 2019) UN Doc CRPD/C/IND/CO/1.

- World Health Organization and Office of the United Nations High Commissioner for Human Rights, *Mental Health, Human Rights and Legislation: Guidance and Practice* (2023).

- Supreme Court of India, *Common Cause (A Registered Society) v Union of India*, MA No 1699 of 2019 (24 January 2023).

5. Secondary Sources

- Davar BV, Pillai K and LaCroix K, 'Seher's "Circle of Care" Model in Advancing Supported Decision Making in India' in Michael Ashley Stein and others (eds), *Mental Health, Legal Capacity, and Human Rights* (Cambridge University Press 2021).

- Duffy RM and Kelly BD, 'India's Mental Healthcare Act, 2017: Content, Context, Controversy' (2019) 62 *International Journal of Law and Psychiatry* 169.

- Gowda GS and others, 'Factors Influencing Advance Directives among Psychiatric Inpatients in India' (2018) 56 *International Journal of Law and Psychiatry* 17.

- Kumar TCR and others, 'Psychiatric Advance Statements: An Indian Experience' (2013) 59 *International Journal of Social Psychiatry* 531.

- Neuman GL, 'Divergent Human Rights Approaches to Capacity and Consent' in Michael Ashley Stein and others (eds), *Mental Health, Legal Capacity, and Human Rights* (Cambridge University Press 2021).

- Philip S and others, 'Advance Directives and Nominated Representatives: A Critique' (2019) 61 *Indian Journal of Psychiatry* S680.

- Shields LS and others, 'Unpacking the Psychiatric Advance Directive in Low-Resource Settings: An Exploratory Qualitative Study in Tamil Nadu, India' (2013) 7 *International Journal of Mental Health Systems* 29.