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How Do Individuals with Alcohol Use Disorders Think About and Respond to Election Dry Days?

To the Editor,

“Dry days,” in which the sale of alcohol is prohibited, are enforced in different states in India. These are usually related to important public holidays. Political elections also invoke “dry days,” which are usually notified in advance.

Individuals with alcohol use disorders (AUDs), who represent 5.2% of the population between the ages of 10 and 75 years in India, may be affected by sudden changes in alcohol availability. A previous report from our center showed a marked increase in the number of complicated alcohol withdrawal before state elections. However, it did not study the knowledge and attitudes of individuals with AUD about these contextual factors.

The general election in Karnataka was held on April 18th and 23rd, 2019 (in two phases), and there was a 48-hour prohibition of alcohol sale before each phase of polling. Hence, patients who are residents of Karnataka and presented to the psychiatric emergency services with alcohol-related clinical presentations (n = 31) between April 17th and 26th were interviewed. We evaluated whether the patients perceived changes in alcohol availability and were aware of election-related “dry days.” This was done by prospectively asking a few additional questions about the pattern of alcohol use prior to their current visit. Further, we also documented the effect of change of availability of alcohol on clinical presentations. Institute Ethical Committee approval was obtained for the study.

The socio-demographic details and clinical presentations are shown in Table 1. Almost half the sample reported an increased availability of alcohol during the pre-election period. Eleven patients (35%) had relapsed to alcohol use in the run-up to the elections, after having been previously abstinent. Nine among them had received alcohol use in the run-up to the elections, after having been previously abstinent. Nine among them had received alcohol use in the run-up to the elections, after having been previously abstinent. Nine among them had received alcohol use in the run-up to the elections, after having been previously abstinent. Nine among them had received alcohol use in the run-up to the elections, after having been previously abstinent. Nine among them had received alcohol use in the run-up to the elections, after having been previously abstinent. Nine among them had received alcohol use in the run-up to the elections, after having been previously abstinent. Nine among them had received alcohol use in the run-up to the elections, after having been previously abstinent. Nine among them had received alcohol use in the run-up to the elections, after having been previously abstinent. Nine among them had received alcohol use in the run-up to the elections, after having been previously abstinent. Nine among them had received alcohol use in the run-up to the elections, after having been previously abstinent. Nine among them had received alcohol use in the run-up to the elections, after having been previously abstinent. Nine among them had received alcohol use in the run-up to the elections, after having been previously abstinent.
same. However, we did not explore the specific reasons behind the same, which is a limitation. A majority (n = 24, 77.4%) of patients supported the election ban, while the remaining were either not sure or were against it. Those in favor of election-related “dry days” believed that it would decrease political violence during that period. Of the patients interviewed, 18 (61.3%) attributed their emergency visit to election-related “dry days.”

Further, we observed that the proportion (n = 20/48, 41.7%) of the total substance use emergency presentations due to delirium tremens was more during the study period when compared to the same period in the preceding month (n = 14/56, 25%). This hints at the fact that there may have been an overall increase in alcohol withdrawal-related presentations; however, these findings should be interpreted with caution.

Based on our results, there seems to be a change in the supply of alcohol, with an increased availability before polling day and a sudden stoppage during polling days, as reported by patients. This was also noted in reports in the popular media based on data from the Election Commission of India. This was seen to lead to an increased number of relapses during election campaigning and complicated alcohol withdrawals during polling days.

This study mirrors results from the previous study from our centre. It contrasts with findings from Brazil, where election-related prohibition was associated with fewer acute alcohol-related presentations, including road traffic accidents. However, the occurrence of alcohol withdrawal presentations was not specifically explored in this study. Relapse among individuals with AUD is known to be related to intrapersonal and interpersonal determinants, among other factors. We contend that elections are a critical environmental factor that may have unanticipated consequences in this population. Systematic modeling of the influence of such external contexts over time is required.

Our results also suggest an increased number of cases who presented with delirium tremens during this period. Untreated delirium tremens is associated with mortality rates up to 15%, which can be reduced to less than 1% with early and appropriate intervention. So, it is critical that doctors at all levels of the health system be equipped to manage such cases.

A majority of patients knew about the “dry days,” but it was worrisome that almost half of them did not take any steps to deal with the situation. Therefore, it becomes vital for patients with AUD and their families to be educated about the risks of medically unsupervised sudden reductions in alcohol use. This could take the form of an advisory to contact the healthcare system to initiate alcohol withdrawal treatment as soon as mild withdrawal symptoms set in.

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TABLE 1.
Socio-demographic and Clinical Details of the Sample (N = 31)

| Characteristics                  | Value |
|----------------------------------|-------|
| Age                              | 36.5  |
| Sex Male (n, %)                  | 31, 100% |
| Socio-economic status BPL (n, %) | 18, 58% |
| Region                           |       |
| Urban Bangalore                  | 16, 52% |
| Rural Bangalore                  | 5, 16%  |
| Other parts of Karnataka         | 10, 32% |
| Case entry                       |       |
| New case (n, %)                  | 13, 42% |
| Reason of presentation           |       |
| Intoxication (n, %)              | 11, 35%  |
| Simple withdrawal (n, %)         | 3, 10%   |
| Complicated withdrawal (n, %)    | 17, 55%  |

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BPL – Below Poverty Line
Mental Healthcare Act, 2017 (MHCA), from Paper to Clinical Practice in the Mental Health Settings

Sir,

The Mental Health Care Act, 2017, was implemented in the country for ensuring the rights of persons with mental illness (PwMI). Since its launch, it has been critiqued by the scientific community, highlighting its shortcomings and issues with implementation. However, such critiques did not explicitly highlight the issues with the implementation of the MHCA in routine clinical discourse. Hence, we intend to highlight the practical challenges in implementing MHCA in the routine clinical practice, based on our experience of following MHCA over the last few years, particularly those related to the nonavailability of Mental Health Review Boards (MHRBs) and community-based mental health (CB-MH) services, and potential ways out.

The MHRB is the main quasi-judiciary body for the enforcement of the law. The foundation of mental health care and rights of PwMI under MHCA involves and requires the active participation of the MHRB. However, because of the lack of the MHRBs, mental health professionals (MHPs) often struggle in balancing between providing quality care to the PwMI and being legally and ethically correct. Some of the contentious issues are highlighted as follows:

- A PwMI admitted to a mental health establishment (MHE) with high support needs (Section 89) should be treated as per one's advanced directives (ADs), if made earlier, and it is the responsibility of the MHRBs to make it available for the MHPs (Sections 5, ss 7). Moreover, revocation, cancellation, or amendment in the ADs must be channeled through the MHRB upon request of the nominated representatives (Section 11(1)). However, ADs are currently not available for the MHPs in most cases because of the absence of a functional MHRB; furthermore, in the absence of the MHRB, any amendment in ADs concerning the treatment (e.g., in case of conflicting opinions of the PwMI, their nominated representatives, and/or MHPs about the treatment) cannot be made, thus posing challenges for the MHPs in providing treatment.

- All admissions of a minor (independent or with high support needs), admission of PwMI with high support needs (female and male), prolonged admission (beyond 30 days; Section 90, ss 1), readmissions within seven days of discharge of a person previously admitted with high support needs (Section 90, ss 3) say for maintenance modified electroconvulsive therapy, drug-related adverse events, worsening of symptoms, etc. are to be conveyed to the MHRBs within the stipulated time. However, the nonavailability of the MHRBs creates an undue fear or dilemma among the MHPs as to how to balance one's clinical decisions with the duty to inform the MHRBs about such admissions, which may discourage them from admitting such individuals or discharging them prematurely (depicted in case vignette, online-only supplementary file 1).

- Similarly, for prohibited procedures (modified electroconvulsive therapy for minors, psychosurgery) and interventional research conducted on a person who is unable to give free and informed consent, approval of the MHRB (Section 95) and state mental health authority (SMHA; Section 99, ss 2), respectively, are required. The lack of MHRBs, also SMHAs in a few states, or the formalities involved therein may adversely affect the clinical decisions (being contemplated or taken for the PwMI) of the MHPs for fear of being scrutinized or facing inadvertent legal consequences.

MHCA rules that the MHPs should not prolong the admission of PwMI for the lack of CB-MH services and to prepare the continuity of care for those requiring repeated admissions (Sections 18, 19, 90, and 98). Because of the nonavailability of the CB-MH services, there is a possibility that a proportion of the PwMI who are symptomatic, yet do not fulfill the criteria for supported admission, ends up becoming long-stay patients in mental health institutions; however, MHCA does not allow this, raising dilemmas on where these patients should be sent? Alternately, the symptomatic person or those at high risk of relapse postdischarge because of the lack of CB-MH services may require a hospitalization beyond 30 days. However, because of the nonavailability of the MHRB, the MHPs may become apprehensive in continuing the hospitalization for not being able to fulfill the formalities.

MHCA mandates monthly reporting to the MHRBs of restraints imposed on the PwMI in the MHEs (Section 97). Similarly, MHRBs are the appellate bodies for the PwMI to register complaints against the MHE for any deficiency in care. However, the absence of MHRBs limits the much-needed supervision on the MHEs and undermines the rights of PwMI (and their caregivers/nominated representatives) to seek redressal for their concerns.

Lastly, MHCA entrusts states to implement the Act (including setting up SMHAs, MHRBs, CB-MH services, etc.; Sections -55, 61, 62, 115[2]). Poor mental health budget and human resources in most of the states may impact their political will to implement the Act, thus can act as an impediment in the setting up of MHRBs.