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]

1 Lloyd-Evans B, Bond G, Ruud T, Ivanecka A, Gray R, Osborn D, et al. Development of a measure of model fidelity for mental health crisis resolution teams. *BMC Psychiatry* 2016; **16**: 427.

2 Lloyd-Evans B, Osborn D, Marston L, Lamb D, Ambler G, Hunter R, et al. The CORE service improvement programme for mental health crisis resolution teams: results from a cluster-randomised trial. *Br J Psychiatry* 2019; doi: https://doi.org/10.1192/bjp.2019.21.

3 NHS England. *Crisis and Acute Care for Adults*. NHS England, no date (https://www.england.nhs.uk/mental-health/adults/crisis-and-acute-care/)

Brynmor Lloyd-Evans, Senior Lecturer, Division of Psychiatry, University College London, UK; **Sonia Johnson**, Professor of Social and Community Psychiatry, Division of Psychiatry, University College London, UK. Email: b.lloyd-evans@ucl.ac.uk

doi:10.1192/bjp.2019.145

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.

1 Duffy RM, Kelly BD. The right to mental healthcare: India moves forward. *Br J Psychiatry* 2019; **214**:59–60.

Aman Mehta, Senior Resident, Department of Psychiatry, Institute of Human Behavior and Allied Sciences, New Delhi, India. Email: aman18april@gmail.com

doi:10.1192/bjp.2019.146

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 workers[2] 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.

1 Patel V, Weiss H, Chowdhary N, Naik S, Pednekar S, Chatterjee S, et al. Lay health worker led intervention for depressive and anxiety disorders in India: impact on clinical and disability outcomes over 12 months. *Br J Psychiatry* 2011; **199**: 459–66.

2 Pathare S, Kalha J, Krishnamoorthy S. Peer support for mental illness in India: an underutilised resource. *Epidemiol Psychiatr Sci* 2018; **27**: 415–9.

3 Thirthalli J, Zhou L, Kumar K, Gao J, Vaid H, Liu H, et al. Traditional, complementary, and alternative medicine approaches to mental health care and psychological wellbeing in India and China. *Lancet Psychiatry* 2016; **3**: 660–72.

Richard M. Duffy, Consultant Psychiatrist, PhD Researcher, Trinity College Dublin, Ireland. **Brendan D. Kelly**, Professor of Psychiatry, Trinity College Dublin, Ireland. Email: duffyrm@gmail.com

doi:10.1192/bjp.2019.147

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 hypothesis[3] on the

https://doi.org/10.1192/bjp.2019.147 Published online by Cambridge University Press