











# The Legality and Ethical Issues of Certifying Laypersons as Mental Health Counselors in India

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## ABSTRACT

**Background:** The burden of mental health conditions and consequent disability impacts are felt most in low- and middle-income settings. These settings are constrained by the limited availability of resources to provide even essential aspects of mental health care (MHC). Task shifting and sharing interventions have shown promise in delivering community-based MHC across such low-resource settings. Some counseling tasks such as friendship bench interventions have been successfully shifted to laypersons. However, ethical and legal concerns regarding laypersons' incorporation in MHC delivery systems have not been examined.

**Purpose:** To examine the ethical and legal concerns surrounding the certification of laypersons as community-based mental health counselors.

**Method:** We undertook an academic review of various legislations pertinent to MHC service delivery and the certification of allied health care professionals to inform

on acceptable and tenable strategies toward incorporating such a task-shifted intervention.

**Conclusion:** Scaling up the training of human resources to address access problems can be the first step in addressing the MHC access and treatment gaps. The certification of laypersons as community-based mental health counselors, although legally tenuous, can be pioneered by tertiary-level MHC institutions. This certification has sound ethical justification and is a progressive step toward realizing universal mental health coverage.

**Keywords:** Lay mental health counseling, Task shifting, Counseling services India, Treatment gap, Ethical issues, Legal issues, Certification of counselors

**M**ental health conditions figure amongst the most common disabling conditions. They also are the second leading cause of disease burden measured in terms of years lived with disability.<sup>1</sup> Their burden is

felt most in low- and middle-income settings,<sup>2</sup> which are resource-constrained to provide even essential aspects of mental health care (MHC) services.<sup>3</sup>

In India, the number of mental health professionals (MHPs) able to deliver quality MHC services is woefully short of the recommended standards. India has about 9,000 psychiatrists, corresponding to 0.75 per one lakh population: only 25% of the recommended WHO standards of three psychiatrists per one lakh population. Numbers for psychologists and psychiatric social workers are lower, 0.069 and 0.065 per 1,00,000 respectively.<sup>4,5</sup> Lifetime prevalence of any mental disorder in India is nearly 14%, not including substance use disorders.<sup>6</sup> A huge treatment gap is also noted: >70% of persons with mental health conditions do not access MHC.<sup>6</sup> Understandably, the numbers of MHPs are inadequate. Protracted training periods imply that scaling up of these human resources

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would not address the problems of access and care gaps in a timely manner.

## Task Shifting Approach: Concept and Evidence

Task sharing or task-shifting approaches have recently gained importance in global psychiatry. Strategically, this means that a simpler part of multi-step MHC services can be carried out by the more numerous less skilled professionals and laypersons alike, after necessary training.<sup>7,8</sup> Many such task-shifting interventions have demonstrated effectiveness in clinical trials. A cluster-randomized trial by a non-governmental organization called Sangath in Goa, studied a collaborative stepped-care intervention “MANAshanti Sudhar Shodh” (MANAS) that offered case management and psychosocial interventions, provided by a trained lay health counselor and supplemented by antidepressant drugs prescribed by the primary care physician, under supervision of a mental health specialist.<sup>9</sup> It found that people in the intervention group were more likely to have recovered at six months than the control group.

In Pakistan, the Thinking Healthy Program by the World Health Organization (WHO) was adapted for delivery by laywomen from the community, to address the treatment gap for pregnant mothers and reduce the morbidity of perinatal depression.<sup>10,11</sup> In this study of 40 village clusters, the intervention was cost-effective and beneficial on some aspects of severity and disability. The friendship bench interventions developed in Zimbabwe have shown promising results even in other sub-Saharan countries such as Malawi and Tanzania.<sup>12,13</sup> The intervention involved manualized delivery of six sessions of problem-solving therapies by trained lay volunteers to those who needed it. Such task-shifting interventions have been adopted by the public health administration in delivering health interventions for other conditions such as HIV/AIDS and tuberculosis.<sup>13</sup> In these studies, details regarding the educational background and qualifications of “laypersons” have not been reported. Readers are referred to a qualitative systematic review on mental health-related tasks shifting to lay health workers (LHW).<sup>14</sup> Apparently,

the lack of formal or professional MHC training qualifies one to be a layperson. Aside from this, such task shifting has also been discussed in developed settings to improve the uptake of psychotherapy services such as the Improving Access to Psychological Therapies (IAPT) program of the National Health Services in the United Kingdom (UK).<sup>14</sup>

## Task Shifting and the National Mental Health Policy

India’s National Mental Health Policy (NMHP), 2014, in its section on “strategic directions and recommendations for action,” discusses measures to increase the availability of adequately trained MHC human resources.<sup>15</sup> 5.5.1 mentions the importance of inclusion of community health workers toward reducing the gap. In 5.5.5, the policy recognizes the need for “lay and community-based counselors” to be adequately trained toward understanding and advocating a better mental health ecosystem. In this manner, the policy recognizes the potential contributions of laypersons in realizing better mental health for all. This policy, however, remains only an advisory document without any enforceable implementation. No follow-through steps are laid down in the policy toward this recommendation’s implementation, nor has it been discussed or elaborated in any subsequent plan or program for MHC delivery. Task shifting and capacity building also find a mention in 5.5.4, where the importance of developing skills and competencies of auxiliary nurses is discussed. NMHP thus recognizes task shifting as a necessary step toward realizing better mental health for all Indians.

## Context for Certification in Task Shifting

The WHO global task-shifting recommendations, launched at the first task-shifting conference include in Recommendation 10 the importance of linking certification, credentialization, and continuing education support initiatives with health care worker training. Furthermore, it calls for registration and career progression avenues for the workers. Such certification or credentialization ought to be nationally endorsed

and standardized.<sup>7</sup> An example quoted involves short-term training in Namibia for counselors who then undergo a skills assessment prior to certification as counselors involved in HIV/AIDS care. This can be done in regard to mental health counseling as well. The recognition placed by the NMHP<sup>15</sup> on such task shifting accords legitimacy to the potential contributions from lay or community-based counselors. Philip and Chaturvedi<sup>8</sup> have discussed the need for certification and recognition of laypersons providing shifted tasks. Such certification and credentialization coupled with educational support could probably provide opportunities for laypersons to be better engaged in providing MHC. Such certification and credentialization accord recognition to the roles they play in improving access to MHC for community members.

## Aim

In this article, we aim to examine ethical and legal considerations surrounding the certification of laypersons as community-based mental health counselors and to obtain further information on their sustainability and incorporation into MHC delivery systems.

## Methods

We undertook an academic review of the legal landscapes, ethical stances, and ongoing practices that would promote or impede the certification of laypersons as mental health counselors. Legal aspects of the review included academic readings of the relevant legislation: Mental Health Care Act, 2017,<sup>16</sup> Rights of Persons with Disabilities Act, 2016,<sup>17</sup> Rehabilitation Council of India Act, 1992,<sup>18</sup> National Institute of Mental Health and Neurosciences Act, 2012,<sup>19</sup> Postgraduate Institute of Medical Education and Research Act, 1966,<sup>20</sup> All India Institute of Medical Sciences Act, 1956<sup>21</sup> as well as the most recent The National Commission for Allied Health Care Professionals Act, 2021.<sup>22</sup>

An exhaustive search was undertaken to list options available for informal or non-standardized training of non-professionals as mental health counselors. We also examined bioethics principles to better understand ethical contexts. Lastly, after deliberations and discussions between the authors

(amongst them community psychiatry, forensic psychiatry, telemedicine, task shifting program faculty, and psychiatric rehabilitation experts), we provide here a framework incorporating these aspects and offer some pragmatic considerations.

## Laypersons as Counselors

Mental health counseling services have also been delivered outside of the health care system to seeking and needy persons by religious organizations or affiliates.<sup>23</sup> For example, parishioners could avail such services at their local churches. Interventions offered would be dissimilar to the standard mental health interventions in these regards—model, approach, general attitudes, and the incorporation of faith-based teachings.<sup>24</sup> Trained MHPs have also contributed to developing such counseling services.<sup>14</sup> Interested members could avail of short-term training and then be inducted into supervised counseling for longer periods. Some of these services will also have group formats to discuss common issues that may be more suited for particular clients. For example, support groups and 12-step facilitation programs incorporate care delivery through peers who became “experts” by their lived experience. These have seen wide acceptance and shown results akin to standard mental health interventions—the most famous of these being the Alcoholics Anonymous and Narcotics Anonymous.<sup>25,26</sup>

Another approach has been to train laypersons or non-MHPs with intervention models and styles that may be used across diagnoses. Some of these include neurolinguistic programming, a method wherein people are trained to better organize their thinking, feeling, language, and behavior. Motivated persons are certified after short-term training of a few days and provided resources to initiate their own practice.<sup>27</sup> Another example of a short-term course is “hypnotherapy” for regular practice. Hypnosis is used to induce a trance to facilitate access to the “subconscious” and guide problem solving.<sup>28</sup> Other schools of therapies such as cognitive behavior therapy and cognitive analytical therapy have also been imparted to non-professionals.<sup>29</sup>

Recognizing the access and availability challenges for psychotherapy services

across the country, institutions have been training nonprofessionals in delivering some psychological interventions. For example, the Banjara Academy has been offering short-term courses in counseling since 1990. It now offers full-year diplomas in counseling skills, certificates in child and adolescent development, and a postgraduate diploma in psychotherapy.<sup>30,31</sup> Psych School is another training center that offers courses in providing psychological interventions.<sup>32</sup> Another organization called Counsellor Council of India<sup>33</sup> offers diplomas and certificate courses across psychological streams for any person but states that to practice independently, trainees must have completed postgraduation.<sup>34,35</sup> Other religious and alternative healing institutions offer training in healing methods that subsume mental health conditions as well. Examples include pranic healing and Reiki.<sup>36,37</sup>

Most importantly, the WHO recognizes the strategy of task shifting as a viable and effective method of care delivery, especially in resource-limited settings. The WHO’s Mental Health Global Action Program (mhGAP) has been initiated to develop training guides for lay volunteers for use across cultures and countries. The mhGAP intervention guide has undergone revisions to remain relevant and is useful for training both prescribers and non-prescribers.<sup>38</sup> The same guide is also available as a smartphone application for use as an algorithm.<sup>39</sup>

Despite some evidence in some settings, it is not clearly known whether these programs and interventions have resulted in changes to health care delivery systems; being volunteer activities, these delivery methods may not be sustainable over longer periods. For sustainability and long-term benefits, these cadres to whom tasks are shifted need to have incentives in the form of remunerations, social credit, or both. Other concerns regarding their own permanence in the MHC delivery systems need to be formalized.<sup>8</sup> Shifting and sharing of tasks in health care delivery also entail the creation of a semispecialized cadre of care providers—most times, they would be out of the purview of the existing regulatory systems and statutory governance. However, benefits (to clients) such

as better access to MHC services and retention may be assured.

With grossly inadequate numbers of clinical psychology professionals and their almost exclusively urban availability,<sup>5</sup> most who need such interventions are unable to benefit. Basic counseling and manualized psychological interventions as tasks have been successfully shifted to laypersons and volunteers from the community. Such projects have demonstrated increased access, effectiveness, and positive outcomes.<sup>40-43</sup>

## Counseling versus Psychotherapy

Counseling as a term has been employed in the past to convey the practice by trained lay providers across many contexts. School mental health counselors facilitate personal, social, and academic development while monitoring the mental and spiritual health of school-going children. Typically, they complete a short-term diploma in guidance and counseling after graduate-level education.<sup>44,45</sup> Career counselors advise on career paths and available options and facilitate decision-making. They are brought together from varied backgrounds in education to undertake at least a short-term diploma.<sup>46</sup> After a short-term training, such counselors are identified as experts for the queries or issues concerned.

Counseling services are different from psychotherapy services. Feltham et al.<sup>47</sup> define counseling as a principled relationship that applies one or more psychological theories using a dynamic set of communication skills that are modified by experience, intuitions, and other interpersonal factors to client’s problems, aspirations, and other intimate concerns.<sup>47</sup> The American Counseling Association outlines the objectives of counseling as a collaborative effort between the counselor and the client aimed at identifying goals and solutions to problems causing emotional turmoil. They also seek to improve communication and coping skills and strengthen self-esteem. Targets include behavioral change and optimum mental health.<sup>48</sup>

Psychotherapy, however, is understood differently from counseling. It is to be performed by trained MHC professionals. There are nuanced differences

between psychotherapists and counselors in their practice and pronounced differences in their qualifications. Psychotherapy or therapy is also available in individual and group formats as counseling: both demand differences in attributes and stances.

The Rehabilitation Council of India is the statutory body that governs the training of clinical psychologists in the country. It provides each with a unique registration number after completing a Master's in Philosophy level clinical training in a recognized institution. A certified clinical psychologist has to undergo a minimum of seven years (three years bachelors + two years masters + two years masters in philosophy) of tertiary education and training. Psychiatric social workers must follow a similar trajectory. They are governed by the recently established Allied Health Care Professionals Commission.<sup>49</sup>

We now examine in the following paragraphs the ethics and ethical issues regarding the institution of such a counseling cadre, especially in the Indian context.

## Legality and Regulatory Aspects

When examining the creation and certification of laypersons as mental health counselors, legal and regulatory nuances must be sufficiently discussed. India, a common law country, considers only violations of legal proscriptions as offenses attracting scrutiny. There are many legislation at the central level that would have to be interfaced with regard to the practice by laypersons as counselors. Amongst these would be MHCA, 2017;<sup>16</sup> RPwD Act, 2016;<sup>17</sup> RCI Act, 1992;<sup>18</sup> and the NCAHP Act, 2021.<sup>22,50</sup>

Alongside these legislation, there are acts of parliament that imbue apex tertiary institutions as those of national importance and provide them autonomy in the development and provision of training courses, notwithstanding prescriptions by the other regulatory bodies and legislation.

The MHCA, India's new and most recent mental hygiene legislation compliant with the United Nations Convention on the Rights of Persons with Disability (UNCRPD), identifies only the following cadre as MHPs:

1. Psychiatrists with a postgraduate degree or diploma in psychiatry recognized by the University Grants Commission (UGC), the National Board of Examinations (NBE), or Medical Council of India (MCI) or its equivalent for those from alternative medicine systems like Ayurveda, Homeopathy, Unani, and Siddha.
2. Clinical psychologists with RCI registration after having completed a two-year M.Phil. in clinical psychology from a program recognized by the UGC.
3. Psychiatric social workers—after completion of two years of training in M.Phil. in psychiatric social work from a UGC-recognized program in the country.<sup>16</sup>

The act emphasizes the rights of persons with mental illnesses and their families and empowers them to register complaints about service deficiencies and rights violations. This is laid down as a stepwise process in Section 28 with the mental health review boards. The state mental health authorities are notified as arbiters aside from the routine mechanisms of approaching the medical councils, consumer courts, or judicial courts. In such instances, such a non-professional cadre would be without statutory bodies to represent or provide expert opinions on the alleged infractions. If these cadres were working independently in the community, they would also face many challenges with no avenues for professional indemnification. Similarly, the RCI act carries a statutory warning that working without the prescribed training attracts heavy penalties amongst other stringent actions. The RCI conducts many courses to empower and even qualify motivated persons with training in the rehabilitation and management of persons with disabilities. However, mental health counseling does not figure in the list. The RPWD act too specifies redressal mechanisms for deficiencies in service and rights violations, similar to the MHCA. The recently enacted NCAHP Act of 2021 has provided a framework for recognizing and maintaining various allied health care professional cadres.<sup>22</sup> The preamble seeks to regulate educational institutions, services, assessment, and training. Amongst the categories, behav-

ioral health care professionals are listed. This act, notified in the Gazette of India on March 28, 2021, now envisages a broad and networked definition of health care professionals to include scientists, therapists, or any other professional who studies, advises, supervises, researches, or provides preventive, curative, rehabilitative, therapeutic, or promotive services after obtaining a qualification as laid down in the act. For a health care professional, the courses have a minimum of 3600 hours of teaching/training spread over three to six years. For an allied health care professional, the requirements for training period and duration have a threshold of 2000 hours spread over two to four years. This act would include mental health counseling courses for laypersons if they were designed to meet the stringent standards specified. Such protracted training periods are incompatible with the short-term goals that make task shifting so relevant.

Institutes of national importance and excellence are created by acts of parliament that also enable these institutions to function as autonomous bodies in the training of health care resources. Amongst the ones that are in the mental health field are: PGIMER, Chandigarh,<sup>20</sup> AIIMS, New Delhi,<sup>51</sup> Jawaharlal Institute of Postgraduate Medical Education and Research, Pondicherry,<sup>52</sup> and NIMHANS, Bangalore.<sup>19</sup>

Section 25 of the NIMHANS Act 19 states thus:

Notwithstanding anything contained in the Indian Medical Council Act, 1956, the Rehabilitation Council of India Act, 1992, the Indian Nursing Council Act, 1947 and the University Grants Commission Act, 1956, the medical degrees, diplomas, nursing degrees and certificates granted by the Institute under this Act shall be recognised medical qualifications for the purposes of the Act aforesaid and shall be deemed to be included in the Schedule to the respective Acts.

This provision empowers the institute to develop courses and train persons in these courses. NIMHANS has its own board that deliberates on its curricula. This mechanism provides for a review of the content, structure, and assessment methods, amongst other aspects.

Lay mental health counseling may be taken up under the aegis of these institutions as an initial proof of concept, with periodic outcome reviews in terms of access and services satisfactions guiding the further acceptance and implementation and even recognition.

## Ethical Considerations

The issue of the integration of LHWs does come with its set of concerns, particularly with reference to the four principles of biomedical ethics.<sup>53</sup>

Most LHWs may be motivated and sensitized caregivers who are experts by experience. One may anticipate that with training in mental health and their induction into care delivery systems, awareness regarding mental health issues would improve. It may also result in improved MHC access for community members. Certification of such training would increase recognition and empower laypersons.

LHWs are an integral part of the community. On account of such proximity, they are more likely to have personal biases: for instance, subscriptions to local cultural, social, sexual, or gender identity, and related beliefs. This might have adverse reactions to the intended outcome of the intervention. This community relationship would also make them likelier to develop better rapport and alliances with the patient's family and community members, especially if they have similar backgrounds. The ethical principle of "non-maleficence" can be highlighted here, and the notion of "do no harm" then becomes an ethical concern when employing LHWs in primary health care systems.

As a public health strategy, such task shifting may have unintentional consequences. Disadvantaged or marginalized groups could find access harder or more limiting when having to engage with peers in the community. Hence, it is imperative to ensure adequate representations of various communities and groups. Often, care delivered by these LHWs may be overly manualized or structured and coupled with an inadequate understanding of its nuances.

Relative to developed settings, low-resource settings such as those of India rely on volunteers with lower educational attainments. In the UK, an improved

access for psychological interventions has been envisaged with the IAPT program in which trainee master's level psychologists take up clients referred for psychological interventions, under supervision.<sup>54</sup> Utilitarian perspectives where more benefit than harm is envisaged and consequentialist arguments where potential and expected outcomes can be weightier than unexpected ones help justify such certification or credentialing for LHWs.

When examining the principle of Justice along with Beneficence, concerns regarding liability for malpractice arise. Typically, when seeking professional help, clients can feel secure knowing there are governing codes of conduct and appellate mechanisms to report grievances. Such codes of conduct and practice ethics are set up by professional bodies. Clients may experience disempowerment when no such redressal mechanisms are made available. From the perspective of LHWs, further concerns of monetary compensation and support during training and supervision come to the fore. Furthermore, when we talk of the principle of justice, LHWs are quite prone to unfair employment opportunities and further exploitation at the hands of those higher up in the matrix. There may also be concerns around the lack of having a voice or being involved in decision-making processes.

Ethical concerns regarding the autonomy of choice can also arise when employing LHWs in the primary health care system.<sup>55</sup> Kottai and Ranganathan<sup>56</sup> quoted that "task-shifting" of health care interventions to LHWs has the danger of becoming "task dumping of stigmatized health care activities on persons who have less power to refuse these jobs."<sup>56</sup> This becomes a concern not only for the LHWs but also for the service user in terms of the limited availability of options.

Aside from these concerns, some issues pertinent to practice as a counselor for mental health issues need to be discussed. These issues are regularly noted by MHPs in their practices and require effective communication skills along with experience for effectively navigating through them. Boundary violations in any counselor-counselee interaction are quite probable. Adequate

sensitization and training in handling such situations are necessary. Confidentiality and its strict observance, with the nuanced understanding of deciding when to break it, are also important. Documentation of sessions and client details are also essential components of training. Reporting of sexual abuse by children and adolescents is also a matter they need to be sensitized about, especially with regard to the laws in the country. Issues of consent and assent are also to be dwelt on during the training. However, ethical concerns of utilizing a non-specialist task force to deliver MHC services need to be systematically studied from the experiences and reports of patients, caregivers, lay mental health counselors, trainers, and other MHPs. These concerns are reflected in Recommendation 9 of the WHO's "Task shifting: Global recommendations and guidelines."<sup>57</sup>

## Pragmatic Considerations and Conclusion

Scaling up training of human resources to address the problems of access can be the first step in addressing the MHC gap. However, it cannot be the one-stop solution to meet this need. The current legal dispositions do not favor the creation or institution of a cadre of laypersons who can perform functions of mental health counseling for community members. This is dissonant with regard to the strategic directions and recommendations framed in the NMHP,<sup>15</sup> which recognized the important role of community-based counselors. In this scenario, task shifting may remain hamstrung as an intervention restricted to research projects. Apex mental health institutions in the country must take the lead in designing and developing training curricula for laypersons to serve the community independently and sustainably. An immediate alteration that can be made would be to include a special category for laypersons and experts/care providers by experience. Such a cadre would have limited recognition and permissions to carry out specific tasks professionals share with them. A uniform code of conduct governing and applicable to them should also be urgently prepared.

Task shifting in this manner ought never to be considered a permanent

fixture but rather as a temporary measure to enhance access to much-needed services until the health care delivery systems are strengthened to cater to the mental health needs of the entire population.

MHC can benefit from the induction of laypersons who can provide basic counseling interventions for community-dwelling persons. Patel, et al.<sup>58</sup> have listed conditions toward the successful delivery of MHC services by laypersons.<sup>58</sup> They are to be recruited from the local community, and they are to be provided with well-designed participatory training based on adult learning principles. They ought to be supervised by specialists with clinical experience, risk management, and experience in clinical governance. Potential advantages that can be noted include reducing morbidity because of common mental disorders and reducing the negative impacts on the productivity on account of mental health challenges. Intuitively, these would be closely followed by improvements in the access and service gaps. Positive impacts on awareness-raising and overall mental health literacy can also be anticipated. These would result in reducing the stigma and stereotyping of persons with mental health challenges or psychosocial disabilities.

The ethical considerations outlined above allow for a positive movement toward the creation and induction of lay health volunteers as mental health counselors who can aid in care plan implementations by making counseling services more accessible.

Many labels and titles exist for persons providing psychological services. These include but are not limited to counselors, psychologists, counseling psychologists, certified counselors, professional counselors, talking therapists, allied therapists, mental health promoters, etc. Short-term capacity building of laypersons to provide counseling services in the community may benefit from differentiating themselves with an alternative title. The examples include allied mental health counselor, community-level counselor, counseling carer, para-counselor, etc. Per the statutes laid out in the allied health care law, those completing graduation may have “allied” prefixed to their title, and those

who have completed postgraduation may not have “allied” in their names. The same act mandates no work experience prior to such training.

Training of human resources must be reoriented to meet the burgeoning demands, with short-term courses emphasizing supervised job performance. The allied health care commission may review existing evidence and validate short-term courses.










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