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COMMENT

# Age and autonomy: An ethical dilemma in community mental health

**PAVITHRA ARUNACHALEESWARAN, ANANT BHAN**

***Abstract***

*Mental illnesses are proven to have their onset in the mid-teens, making early mental healthcare interventions necessary among adolescents. While school-based mental health awareness programmes have gained prominence in recent years, adolescents identify issues around confidentiality, privacy and the need for parental consent impinging on their autonomy, as barriers to accessing mental healthcare, for their perceived needs. We aim to discuss the various ethical dilemmas faced by community mental health providers in using age as a sole marker for determining autonomy for adolescents, focusing on the potential impact of these challenges on adolescent mental healthcare and wellbeing.*

Authors: **Pavithra Arunachaleeswaran** (corresponding author — pavithra@scarfindia.org), Schizophrenia Research Foundation, R/7A, North Main Road, Anna Nagar West Extension, Chennai – 600 101, Tamil Nadu, INDIA; **Anant Bhan** (anantbhan@gmail.com), Researcher, Bioethics, Global Health, Health Policy, Bhopal; Sangath (Bhopal hub), INDIA.

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## Background

Adolescence is a crucial transitional stage from childhood to adulthood, where individuals experience a series of behavioural and neurocognitive changes that may potentially impact their mental health [1]. Roughly, half of all lifetime mental illnesses are known to have their onset in the mid-teens and frequently demonstrate a course characterised by chronicity and multiple episodes of relapse, often persisting through many decades of productive adult-life [2, 3]. There is evidence that this trajectory of mental illness can be modified through early intervention services for youth mental health during this critical transitional phase [4]. However, young people are less likely than other age groups to access mental health services for reasons such as stigma, reduced mental health literacy, poor access to appropriate services and inadequate health system structures [5]. With the knowledge that the timing of intervention is critical to preventing adverse outcomes and promoting mental health and wellness among adolescents, the World Health Organization 2022 Mental Health Report [6] emphasises the need for enhanced community and school-based interventions for improved access to care.

In line with this objective, Schizophrenia Research Foundation (SCARF) conducts several youth mental health

outreach programmes at schools and community gatherings in Chennai, by engaging with school-going children, across different age groups and socio-economic strata. The goal of these outreach programmes has been to enhance awareness and mental health literacy among adolescents and improve their attitude towards seeking help. Surveys and interviews have been conducted with adolescents to better understand their mental health needs and the barriers faced by them in accessing care. A few of the reflections from these interviews and feedback from the adolescent respondents have been described below. Of the multitude of barriers to mental healthcare access, two important areas of concern for adolescents included:

***Lack of parental support to seek help***

Some adolescents suggested that the parents needed to be educated about mental health and convinced of the need for them to reach out for help, while some reported that parents never considered their problems as serious and would not allow them to access mental health services, such as visiting a psychiatrist, as a result of lack of understanding or concerns about the stigma attached to mental health conditions.

***Fear of their privacy and confidentiality being breached***

The adolescents reported that they were concerned that the community mental health providers (cMHPs) would reveal their "secrets" to their parents, causing more problems in the family, due to conflict of opinions with their parents. This further resulted in avoidance of help seeking and hesitation about opening up to health professionals, which has also been reported in other studies across different countries [7-9].

These barriers reported by adolescents relate to the conflict between legal and ethical guidelines around the need for parental consent and the inability of adolescents to exercise their rights to autonomy, privacy and confidentiality that any "adult" person has. While one of the most important missions of medical ethics is to protect the right of all individuals and ensure that they exercise autonomy within their intellectual ability and fullest capacity, the current Indian scenario vests this discretion primarily in the age cut-off criterion, using age as the surrogate marker for maturity and capacity among adolescents, resulting in the cMHPs struggle with issues around "Should an adolescent be allowed autonomy in the interest of their mental health and wellbeing? Should age be the primary element dictating autonomy?"

This article aims to discuss the various ethical dilemmas faced by cMHPs in using age as the sole marker for capacity, and in turn the sole determinant of agency and autonomy for adolescents, focusing on the potential impact of these quandaries on adolescent mental healthcare and wellbeing.

## Discussion

> *A 17-year-old girl with ongoing relationship issues with her partner presents to the out-patient department of a mental health clinic with complaints of low mood, loss of interest, reduced sleep, frequent crying spells and reduced focus in studies. She reports that she often resorts to harming herself or drinking alcohol as a way to cope with her difficult situations. She does not report any suicidal thoughts and reports having reached out to seek help, following a mental health awareness programme that was conducted at her school. She informs the cMHP that she is willing to take continued medical and psychological treatment as required, but reports that her parents were unaware of her seeking help and insists that they not be informed, as they will neither be supportive of her treatment course nor of her relationship.*

This is not an uncommon clinical scenario in our current setting. The clinical management might have been quite straightforward, had the patient been 18 years old, and hence an adult, instead of 17.

In the current scenario, the cMHP is faced with the dilemma of the consequences of treating the patient, an adolescent, a "minor", without the explicit consent of their parents (or guardians), versus the ethics of not treating a person seeking mental healthcare, unless the parents get involved and consent. On the other hand, the provider must recognise that enforcing the latter condition might lead to the adolescent not being able to access care, which could lead to further mental health complications.

This dilemma also intersects with the recent Mental Healthcare Act (MHCA 2017) norms that state:

> *"A minor shall be given treatment with the informed consent of his NR (Nominated Representative)."*
>
> *"If the NR no longer supports admission of the minorunder this section or requests discharge of the minor from the MHE (Mental health establishment), the minor shall be discharged by the MHE."* [Chapter XII Sec 87]

In the context of the MHCA, a nominated representative — referring to the parent/s or legal guardian of the minor — bears the entire onus of making mental health decisions for the minor. In the absence of a recognised nominated representative, this responsibility is transferred to the concerned mental health board, discounting the preference, and in turn autonomy, of the minor in question.

Beauchamp and Childress state that "personal autonomy is, at minimum, self-rule that is free from both controlling interference by others and from limitations, such as inadequate understanding, that prevent meaningful choice" [10]. When it comes to adolescents, the understanding of the consequences of the choices they make is assumed to be limited owing to their age and the lack of worldly experience that comes with it. However, the understanding of the parents may also be considerably limited, on account of their knowledge and attitudes with regard to mental health. This might mean that they are not in a much better position to make choices on behalf of the

adolescent, resulting in disregard of the adolescent's choices or willingness to access mental healthcare. While this in general emphasises the need for improving mental health literacy among both parents and adolescents, the norm that mandates parental involvement in an adolescent's access to mental healthcare makes the process difficult and inaccessible to adolescents. This underlines the need for flexibility in the mechanism to avoid losing adolescents, often from marginalised backgrounds, from the care pathway, when they most require help.

The MHCA also does not adequately lay out norms for outpatient services in mental health for minors, and does not differentiate between medical and psychological services offered. While most adolescent patients may benefit from outpatient care, the cMHP is ambivalent about starting the necessary treatment, without parental consent, due to the obscurity of the stipulated norms. The Act does not consider the distinction between the nature of the illness, and the levels of insight or capacity of the minor to make decisions. This adds to the legal ambiguity for the mental health provider, owing to possible legal implications, especially in case of adverse events related to the prescribed treatment, or in the course of the illness itself, such as suicide. This is grossly in conflict with their ethical responsibility of providing recommended care in the best interest of the patient, here a minor.

The emphasis laid on the age criteria in decision-making and autonomy prescribed by the MHCA is evident from the following statement:

> *Where a minor has been admitted to a mental health establishment under section 87 and attains the age of eighteen years during his stay in the mental health establishment, the medical officer in charge of the MHE shall classify him as an independent patient under section 86 and all provisions of this Act as applicable to independent patient who is not minor, shall apply to such person."* [Chapter XII, Sec 88(2)]

Though the rationale to these stringent norms ordained in the MHCA aims to safeguard minors, the very assumption that an individual below 18 years of age lacks maturity and capacity to take decisions at all times is arbitrary and in conflict with various real-life circumstances. This may face pragmatic constraints, such as, minors who do not have parents or nominated guardians; or whose parents have mental illness; are neglectful or uninvolved parents; or parents who are not convinced to seek professional help, while the minors perceive its need.

In India, where, despite government norms, there is still a high prevalence of marriage below the age of 18 [11], legal guardians for females below age 18 nominally remain their parents. Considering most girls, after marriage, live with their husbands and in-laws, obtaining consent from their parents brings practical constraints, further affecting healthcare access for the young girls [12]. Besides, while marriage entrusts them with the responsibility of managing the family and primary care of their children, if any, being denied the basic right and autonomy to make their own healthcare choices, citing age as a criterion, is highly contradictory.

On the other hand, many adolescents below age 18 taking professional courses in colleges far away from home are often required to stay without parental supervision and are inherently expected to make many decisions on a daily basis for themselves. However, the legal requirement of parental consent for approaching mental healthcare services, in case of perceived need, only challenges their autonomy and ability to make decisions, further restricting their chances of seeking help, with possible adverse outcomes in their mental health and wellness, at a time when they might be struggling to adjust to a different environment.

Siddeshwara et al [13] also pointed out that while the Juvenile Justice Act (JJA 2015) allows 16- to 18-year-old adolescents to be tried as adults for heinous crimes, adolescents under the age of 18 are paradoxically denied the right to make mental health choices. Though the comparison is not between heinous crimes and mental illnesses, the difference in the presumption of cognitive maturity points out the existing contradiction within the legal system. This needs to be discussed and addressed, keeping in mind the healthcare requirements of minors, and their best interests.

## Recommendation

The controversy in pairing age with autonomy in medical law dates back to as early as 1967 in the case of *Smith vs Seibly* [14] and the case of *Gillick vs West Norfolk and Wisbech area health authority* [15], in 1986. While the current medico-legal system in India holds an arbitrary age mark for determining autonomy, Grubb et al [16] argue that children pass through three developmental stages on their journey to becoming autonomous adults namely: (i) The child of tender years; (ii) The Gillick competent child and (iii) The 16- or 17- year old child. The United Nations Convention on the Rights of the Child (UNCROC) [17] recognises and ensures that the state takes note of the increasing autonomy of children in decision-making, as they mature. This has been adopted in countries like the USA and Canada, through the emancipation of minors and the "mature minor" doctrine [18]. In the US, emancipation laws free the adolescent from all parental and legal control and also free the parents or legal guardians from the responsibility of the emancipated minors, in concordance with the state laws, which may or may not require formal court declaration. However, this needs further consideration in line with the socio-economic sustainability of the emancipated minor. On the other hand, the mature minor doctrine, in force in the USA and Canada, legally recognises the medical decision-making capacity of adolescents, especially in the sensitive areas of sexual and

reproductive health and mental healthcare, without parental consent, even though they are still minors under parental or legal guardian control [19].

Gillick's competency tests [20] and the Fraser guidelines have been ratified to assess the intelligence and maturity of children under 16 to make treatment-specific decisions, taking into account the adolescent's understanding of the information, ability to weigh risks and benefits, short-term and long-term impacts of the decision, the complexity of which increases with the increasing gravity of the situation.

India, though a party to the UNCROC, has been hesitant in adopting the mature minor doctrine, in view of the potential threat to the authority of guardians or parents over the child, in the existing deep-rooted socio-cultural tradition and family sentiments. Adolescents often expect privacy, confidentiality and non-disclosure to parents, as a prerequisite for seeking help for their mental healthcare, but this may be in conflict with the parental expectations of having control over the choices made by their children, as a result of the social and financial oversight they hold towards them.

The legal constraints superadded by the existing socio-cultural norms aggravate the ethical qualms of a cMHP, who is often mandated to take a legally safe stand, which might end up foregoing the best interest of the adolescent. Hence, initiating further discussions about increasing flexibility with respect to the requirement of parental consent for access to mental health services by adolescents is of utmost importance to improve their access to treatment. The exemption of parental consent for Covid-19 vaccination among adolescents in India [21], may serve as an exemplar for incorporating adolescent autonomy in mental healthcare practices as well. In-depth exploration of different stakeholder perspectives in this arena may facilitate adaptation of the mature minor doctrine to suit the socio-cultural setting in India, ensuring adequate leeway for cMHPs to offer mental healthcare services to adolescents without qualms regarding legal repercussions.

Though this may appear to be an individual cMHP's dilemma pertaining to a clinical setting, this could also operate at a larger scale as an ethical question from a community health perspective: What good are our mental health interventions targeted at adolescents, if we are unable to act on them, and implement them with fidelity and quality, in view of conflicts between age and autonomy?

## Conclusion

While the requirement of parental control over making healthcare choices was enforced to ensure the safety and wellbeing of minors, it is important to recognise that the disregard of individual rights and autonomy for minors in favour of age restriction can be detrimental to their healthcare access and wellbeing, especially from a mental health perspective. Hence, it is vital for us to explore instituting a "mature minor" doctrine for mental healthcare, and institutionalise a framework to address the current arbitrariness of leaving adolescent treatment choices primarily in the parental (or guardian) domain, and ensure fair representation of minors' interests and autonomy so as to promote adolescent mental health, and access to timely services.

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***Conflict of Interest:*** *None applicable.*

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RESEARCH ARTICLE

# Ethical challenges faced by community mental health workers in urban Chennai

**VIJAYA RAGHAVAN, G SANJANA**

***Abstract:***

*Background: Delivery of mental health interventions to youth in schools requires a cadre of community mental health workers (CMHWs) in addition to psychiatrists. Literature is sparse in the India context on the ethical and professional challenges faced by CMHWs, especially those working with youth. Hence, the aim of the study was to understand these challenges faced by CMHWs working in schools in urban Chennai and explore ways to overcome them.*

*Methods: A qualitative study was done with CMHWs involved in the delivery of youth mental health (YMH) interventions, including mental health literacy, screening for mental disorders and mental health support to youth in schools in urban Chennai. Focus group discussions (FGDs) were conducted with the study participants and audio recorded. Transcription of the recording was done verbatim and coded for themes using a thematic analysis approach.*

*Results: Two FGDs were conducted with a total of eight participants. The mean (± standard deviation) age of the participants was 27 ± 3.7 years; all having a master's degree in either psychology, social work, or public health. The major themes that emerged were the meaning of ethics and professionalism, confidentiality, dilemma in decision making, incongruence between the requirements of student and school administration, and personal and professional challenges faced by CMHWs. Recommendations to overcome these challenges were also explored.*

*Conclusion: The results indicate CMHWs face significant ethical challenges with confidentiality, and decision making while delivering YMH interventions in schools, highlighting the need for designing and implementing a framework to address these challenges.*

***Keywords:*** *ethics, professionalism, community mental health, mental health professionals, youth, schools, challenges, recommendations*

Authors: **Vijaya Raghavan** (corresponding author — vijayaraghavan@scarfindia.org), Schizophrenia Research Foundation, R/7A, North Main Road, Anna Nagar West Extension, Chennai — 600 101, Tamil Nadu, INDIA; **G Sanjana** (gsanjana@scarfindia.org), Schizophrenia Research Foundation, R/7A, North Main Road, Anna Nagar West Extension, Chennai — 600 101, Tamil Nadu, INDIA.

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## Introduction

The World Health Organization (WHO) defines young people and youth as individuals in the age group between 10-24 and 15-24 years, respectively [1]. India is one of the countries with the highest number of youths — comprising nearly 30% of the total population — under 24 years of age [2], distributed in workspaces in both organised and unorganised sectors and communities, and educational institutions [3], who are viewed as a potential focus for mental health services [4].

Most mental health disorders start usually in mid- and late-adolescence or early adulthood [5]. Various biological, psychological, and social risks, and protective factors play interactively in the emergence of mental disorders among youth [6]. A meta-analysis from Indian studies estimated the prevalence of child and adolescent psychiatric disorders at 6.46% in the community and 23.33% in schools [7]. The variation in the prevalence among youth could be due to differences in settings, age groups studied, methodology and tools used to assess mental health disorders. Similarly, a meta-analysis of 13 psychiatric epidemiological studies from