MINORITY AND MENTAL HEALTH: PROBLEMATICS OF AN UNPROBLEMATIC APPROACH

I Introduction

THE ATTRIBUTION of incapacity to minority stems from the need to protect from exploitation, persons who lack sufficient maturity to decide for themselves. A lower threshold of responsibility, the facility of surrogate decision-making with an option to retract on attaining majority and lack of legal recognition to contractual commitments of minors are some of the mechanisms of protection.

Minority normally extends upto the age of eighteen years. Its disqualifications however do not extend to all actions of a minor in that period. An offence committed by a child below the age of seven years is not punishable.[1] Criminal culpability principles attach to offences committed above that age.[2] Adjudication and disposition however occur not under the adult criminal justice system but under the juvenile justice system.[3] A contract by a person below the age of eighteen years is void *ab initio*.[4] Yet only the employment of children below the age of fourteen years in factories, mines and hazardous occupations is prohibited.[5] In the legislative specification of the minimum age of marriage the eighteen years benchmark is observed.[6] Infringement of the specification does not invalidate the marriage.[7] Section 13(2)(*iv*) of the Hindu Marriage Act 1955 grants a girl who was less than fifteen years when her marriage was solemnised to repudiate her marriage (whether consummated or not) before attaining the age of eighteen years. A similar option in regard to property is available to a woman under section 2(*vii*) of the Dissolution of Muslim Marriages Act 1939 provided the marriage has not been consummated.

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1. See, s. 82, Indian Penal Code 1860.
2. *Id.* s. 83.
3. The Juvenile Justice Act 1986 constructs an exclusive system of criminal justice and child welfare for juveniles. See, s. 2(*h*) of Act.
4. S. 11, Indian Contract Act 1872. For judicial interpretation of the incapacity see, *Mohoree Bibi* v. *Dharmodas Ghose*, (1903) 30 I. A.114.
5. Art. 24, Indian Constitution.
6. The Child Marriage Restraint (Amendment) Act 1978 has defined child as a person who if a male, has not completed twenty-one years of age and if a female, has not completed eighteen years of age.
7. *Naumi* v. *Narotam*, A.I.R. 1963 H.P. 15; *Mohinder Kaur* v. *Major Singh*, A.I.R., 1972 P. & H. 184; *Gindam* v. *Barelal*, A.I.R. 1976 M.P. 83; *Sukram* v. *Mishri Bal*, A.I.R. 1979 M.P. 144. In *R. Pullamsetti* v. *D. Srirammulu* A.I.R. 1968 A.P. 375 and *P.A. Suramma* v. *G. Ganapaty*, A.I.R. 1975 A.P. 193 the Andhra Pradesh High Court held that contravention of the age clause would render the marriage void *ab initio*. This view was however overruled by the Full Bench of the High Court in *P. Venkataramana* v. *State*, A.I.R. 1977 A.P. 43 (F.B.).

The legislative regime for the child is thus an admixture of dependence and responsibility with emphasis on either component varying from transaction to transaction. It could be contended that this dual regime is an exemplification of a paternalistic double speak whereby the child is responsible for her actions but not empowered to decide for herself.

This disempowerment though long practised has no longer remained unproblematic. The presumption that adults are better protectors of the rights of the child has increasingly come to be questioned in recent years. A number of research investigations have been undertaken in USA to assess the competence of young persons to provide consent in several different situations and to understand their rights in general. Whilst conceding that each competency required separate research attention, the investigations have almost consistently found that children are more similar to adults than the law assumes in both the choices made and the logical processes followed. Decision making similarities were especially found between adults and minors—15 years and older—with regard to waiver of rights or consent to medical procedures.[8]

Even in India initiatives whereby children are acquiring the right to speak for themselves have been gaining momentum. The induction of the autonomy component has been occurring segmentally. The, (*i*) grant of lawyering facilities in juvenile court proceedings,[9] (*ii*) permitting a minor girl to bear a child against stiff opposition from her father,[10] (*iii*) recognition to the intelligent opinion of the child in custody proceedings[11] are useful illustrations of such moves. And the controversy emanating with the introduction of each of the above measures provides evidence of the continuous tension between the competing dictates of protection and autonomy.

Recognition to notions of autonomy is further complicated when the disability of "unsoundness of mind" is superadded to the disadvantage of minority. This paper analyses how the competing notions of autonomy and protection are addressed in the realm of mental health treatment of minors.

II Models of legal regulation

Legal regulation of mental health treatment of minors has varied, depending upon whether protection or autonomy has been the dominant motivating factor. The models of legal regulation subsisting in the field can be categorised as Guardian Dominant Model (GDM)) and Minor Dominant Model (MDM).

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8. For reporting of such research see, Edward P Mulvey, "Law and Mental Health Issues Affecting Minors : Research Directions" in Saleem A. Shah and Bruce D. Sales(ed.), *Law and Mental Health: Major Developments and Research Needs* 115 at 121 (1991).

9. The Children Amendment Act 1978 amended the Children Act 1960 to allow a lawyer to be present in proceedings before a children court. S. 28(1) of the Juvenile Justice Act 1986 retains the permission granted under the Children Act. For further discussion on the provision see, Ved Kumari, *Treatise on the Juvenile Justice Act* 209-10 (1993).

10. "Court Allows Minor to Bear Child", *The Hindustan Times*, 3 Dec. 1993 (Delhi) reporting a division bench decision of the Madras High Court.

11. See, Kumud Desai, *Indian Law of Marriage and Divorce* 339 (1993).

(1) Guardian dominant model

This is the older model which stems from the dependency status of the minor. Herein the guardian as the absolute and unquestioned caretaker of the child decides on the child's health care needs, including the need for institutional care and other therapeutic and surgical interventions. This absolute authority of the guardian ceases for non-mentally ill persons on expiry of minority. However, for persons with mental disability, ceasure of minority may in no way affect the dependency status, except to the extent that continuance of the guardianship may sometimes be dependent on the order of a court of law.

The evident problematic in this model is that it presumes absolute identity of interest between guardian and minor. There is no mechanism by which the child's view can be inducted in the decision-making process. Thus even the possibility of conflict of interest is not recognised, whilst possibilities of the perpetuation of the dependency are continually present.[11a]

(2) Minor dominant model

In this model the primary autonomy to take health care decisions rests with the minor. Surrogate decision-making takes over only if the minor due to psychiatric condition is unable to exercise judgment. Thus unsoundness of mind and not minority operates as the incapacitating factor.

The primary difference between this model and GDM is that here decision-making by the minor is the first option hence the minor's views are an integral component of the decision-making process. Decisions by guardians and other surrogates are last resort options with clearly defined limits.

The primary difficulty with this model is that it is not family friendly. Clearly demarcated boundaries curtail not just malevolent but also beneficient family interventions. The family unfriendly contention has been open to question. The counter argument being that if a child is injured and angry enough to sue his parent, denying the child a legal remedy will neither soothe the child nor promote harmony in the family. Judicial non-intervention in the context of voluntary admissions, it is contended, supports the integrity of the family only in the sense that it allows the parents in a dysfunctional family to deny the existence of real family problems by blaming them on the illness of one of their children.[12]

III Legal regulation of mental health treatment of minors

(1) Mental Health Act 1987

Procedures for mental health treatment of minors have been included in the

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11*a*. The U.S. Supreme Court in *Parham* v. *J.R.*, 442 U.S. 584 [1979] opting for this model held that a juvenile had no legal right to contest his parental decision to seek commitment. For a critique of the decision see, Fred R. Mabbut, "Juveniles, Mental Hospital Commitment and Civil Rights: The Case of Parham v. J.R.", 19 *J. Fam. L.* 27 (1980-81).

12. Note, "Voluntary Admission of Children to Mental Hospitals : A Conflict of Interest between Parent and Child", 36 *Maryland L. Rev.* 153 (1976-77).

Mental Health Act of 1987 (MHA) and the Juvenile Justice Act 1986 (JJA). MHA regulates the institutional treatment of persons with mental illness. Persons with mental retardation have been excluded from the purview of MHA.[12a] Institutional treatment of persons with mental retardation is not statutorily regulated.

According to MHA,[13] institutional treatment can be obtained for minors on the application of their guardians to the head of psychiatric institutions. An application for institutional care by a person with mental illness and an application of a guardian for institutionalisation of his ward have been equated in the statute. Both admissions are termed voluntary.[14] Thus an identity of the ward distinct from the guardian is not recognised.

The presumption of identity of interest has been further reinforced by section 81. The section permits the user of a mentally ill minor for research even if such research is not of direct benefit to him for purposes of diagnosis or treatment, so long as written consent of the guardian has been obtained.

A minor institutionalised by the guardian has been empowered[15] to seek his discharge on attainment of majority. Such discharge if sought has to be made within a period of twenty four hours. The medical officer need not make this discharge if he thinks such discharge is not in the interest of the patient and this opinion is confirmed by a medical board of two other officers. The institutional treatment of the patient can continue for a period not exceeding ninety days at a time.

(2) Juvenile Justice Act 1986

Institutionalisation of persons of unsound mind can also occur under JJA. This statute provides for the care, protection, treatment, development and rehabilitation of neglected and delinquent juveniles. The statute empowers[16] the state government to transfer inmates of special homes (delinquent juveniles) or juvenile homes (neglected juveniles) to mental hospitals if of unsound mind.

Under MHA the guardian has been empowered to take institutionalisation decisions for his ward. Under JJA, this power has been arrogated by the state. Compulsory commitment of the delinquent juvenile is an exercise of the police power of the state.[17] The scope of the authority is similar to that being used against adult prisoners.[18]

Involuntary commitment of neglected juveniles stem from the *parens patriae* power of the state. And herein due to wide definition of neglected juvenile the scope of state authority is much wider than that exercised against the adult mentally ill.

12*a*. S. 2(*L*), Mental Health Act.

13. *Id.* s. 16.

14. *Id.*, ss. 16, 17. On the problematic of such categorisation see, James W. Ellis, "Volunteering Children : Parental Commitment of Minors to Mental Institutions", 62 *Calif L. Rev.* 840 (1974).

15. S. 18(2), MHA.

16. S. 48 (1) of the Juvenile Justice Act 1986.

17. For the distinction between "police" and "*parens patriae*" power of the state see note, "Developments in the Civil Commitment of the Mentally Ill", 87 *Harv. L. Rev* 1190 (1973-74).

18. See, *s.* 30, Prisoners Act 1900.

The neglected juvenile is only a recipient of state welfare largesse (primarily consisting of institutional protection) under JJA. She has been given no choice to decide whether or not such largesse is desired. In this umbrella of institutional protection mental hospitals have also been included. The protection of JJA is available to girls upto the age of 18 years and boys upto the age of 16 years. Their institutionalisation in a mental hospital can continue beyond that period if a medical officer considers it necessary for the proper treatment of the juvenile.[19] Thus the denial of choice during minority continues even after assumption of adulthood.

IV Inadequacies of legislative order

If the above scheme of legislative regulation is to be categorised in accordance with the above discussed models it could stated to be GDM inspired. It also needs to be noted that the scheme has been framed in ignorance of the autonomy protection divide and viewed as one of "allocation of authority". Presuming upon the incapacity of minors the legislations inform who could decide for them.

A person with mental disorder may because of his disability be unable to decide for himself; however such incapacity is not co-extensive with mental illness. It has already been pointed out in the introduction that the dependency consequences of minority are not uniform. And yet this range of capacity has not been recognised whilst regulating the mental health treatment of minors. Thus minors who are capable of taking their own treatment decisions have been treated similarly with minors who are not so capable.[20] This lack of classification is especially problematic because attainment of majority and resumption of personhood is not a simultaneous process for the mentally ill. Illustratively the institutionalisation of an inmate of a psychiatric institution can be continued after attainment of majority, against his will, on medical orders.[21]

Institutional placements foster dependency by reducing patient's ability to function in the outside world. Psychological research has stressed that certain degrees of freedom of movement association and communication are critical to the psychological well-being of the child. Insofar as hospitalisation may entail substantial periods of isolation particularly in the case of recalcitrant children, it should be a last resort option.[22] Elimination of alternatives less restrictive than institutionalisation is however not required by MHA.

Institutionalisation vitally affects other civil rights of persons with mental illness. Thus an inmate of a psychiatric institution could be held incapable of having the capacity to marry, contract, vote or manage property.[23] Such a conse-

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19. *Supra* note 16.

20. A number of studies stress that a distinction should be made between adolescents and pre adolescents. See, Note, "The Mental Hospitalization of Children and the Limits of Parental Authority", 88 *Yale L.J.* 186 (1978); Lois A Weithorn "Mental Hospitalization of Troublesome Youth : An Analysis of Sky rocketing Admission Rates", 88 *Stan. L. Rev.* 773 (1988). Also, Ellis, *supra* note 14.

21. S. 18 (3), MHA.

22. Lois A. Weithorn, *supra* note 20.

23. For a detailed analysis of the effect of a psychiatric institutionalisation on other civil rights see, A. Dhanda, "A Critical Appraisal of the Laws relating to the Mentally Ill" thesis submitted to the University of Delhi for the degree of Doctor of Philosophy in March 1993.

quence can occur even with medical commitments as there is no disclaimer in MHA, which delinks an individual's capacity to exercise his rights from his need for institutional care.[24]

No safeguards against these wide ranging consequences on the life and liberty of a minor have been introduced presumably placing trust upon the benevolent intentions of the guardian. The guardian it is presumed will necessarily act in the best interests of the minor. It is not appreciated that parents make the decision to commit at a time of great emotional stress hence are unable to carefully consider less restrictive alternatives.[25]

As protection against any error of judgment by the guardian, professional assessment of parental request has been provided. Thus admission of a minor in a psychiatric hospital can only occur if the medical officer-in-charge of the hospital consents to the same.[26] Ellis in his study on parental commitment of minors to mental institutions[27] questions the wisdom of this trust in professional competence. He holds that the performance of psychiatrists in pre-commitment interviews is perfunctory and tending towards over-diagnosis. The inadequacies of the precommitment procedures Ellis contends cannot be remedied by an early discharge because the impersonal nature of day to day hospital operation makes immediate identification unlikely.

A guardian, it needs to be pointed out, need not necessarily be the parent of the minor. Other close relatives whether or not appointed by court qualify to be guardians.[28] And under JJA the role of guardian has been assumed by the state. Thus the presumption of "benevolent intention" and "identity of interest" cannot be made with the same rigour in relation to all the above categories of guardians. The possibilities of conflict of interests increases when the guardian is a relation other than a parent. And when the role of guardian is performed by the state, assumption of such absolute powers of surrogation seems constitutionally suspect.

Further can even "benevolent intentions" sufficiently guard against the misuse of the absolute authority conferred on guardians - of sanctioning non-therapeutic research. In order to protect the rights of minors in the realm of mental

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24. For the necessity of such a disclaimer see, A. Dhanda, "The Mental Health Bill of 1981 - A New Deal for the Mentally Ill?", *S.C.C. Jn.* 8 (1984).

25. James Ellis, *supra* note 14. Also see, Carol Warren and Patricia Guttridge, "Adolescent Psychiatric Hospitalization and Social Control", in Linda A Teplin (ed.), *Mental Health and Criminal Justice* 119 at 128 (1984).

26. S. 17(1), MHA.

27. James W. Ellis, *supra* note 14.

28. S. 4(2), Guardians and Wards Act 1890 defines guardian as "a person having the care of the person of a minor or of his property or of both his person and property". Prior to its repeal in 1978 s. 6 of the Hindu Marriage Act 1955 specified a range of relatives who had the right to give a minor in marriage. In Muslim law according to the *Sunni* school the right to contract a minor in marriage belongs successively to the father, grand father, brother and other relations on the father's side. In default of paternal relations the right devolves upon the mother, maternal uncle or aunt and other maternal relations within the prohibited degrees. In the *Shia* school however only father and paternal grandfather can be marriage guardians. See, *supra* note 11 at 133.

health treatment legislations need to address issues such as, (*i*) capacity of minor to decide for herself; and (*ii*) surrogate mechanisms in the face of incapacity. In the construction of the accountability mechanisms, distinctions would need to be introduced, depending upon whether the power is conferred on the parent, the professional or the court. Also the scope of the surrogate's authority would need to be specified.

A legislative structure seems imperative as without statutory controls the constitutional dictates are observed more in the breach. The necessity of accountability mechanisms and the mechanical denial of personhood which occurs with an attribution of mental disability can be appreciated in the light of the recent 'womb removal' controversy.

V Breach of constitutional rights : womb removal of women with mental handicap

The removal of womb of 16 mentally handicapped women living in a government institution for mentally handicapped females was ordered by the institution managers. The physical age of these women ranged from thirteen to thirty seven years. Whilst the uteri of eleven women were removed, hysterectomies of the remaining five were stopped, after women activists protested to the Chief Minister of Maharashtra.[29]

Institutional managers and doctors contended the hysterectomies were necessary as a hygiene promotion measure. Womb removal would also save the women from unwanted pregnancies as due to their mental condition they were unable to rear children. Human rights groups and women activists condemned the government intervention as fascist. The operations, it was argued, increased the women's vulnerability to sexual exploitation.[30]

This advocacy of the basic human rights of women with mental handicap was rebutted by institution managers, doctors and ministers by issuing invitations to human rights activists to take care of women during their menstrual period. The, (*i*) inability of women to look after themselves, (*ii*) shortage of attendants, and (*iii*) difficulties in getting the available attendants to keep the menstrual rags clean were cited as reasons compelling the womb removals. The increased danger of sexual exploitation, a doctor suggested, could be met by "permanent closure of the vaginas of severely retarded girls."[31]

Article 21 of the Indian Constitution lays down that no person shall be deprived of his life and liberty except according to procedure established by law. This fundamental right to life and liberty has been guaranteed to all persons including persons with mental handicap. The right requires that any deprivation of liberty should occur by a legislatively prescribed procedure which has to be

29. *The Hindustan Times*, 7 Feb. 1994 (Delhi).

30. A. Goswami Nafday, "We Can't Have a Quick-fix Solution", *The Indian Express*, 14 Feb.1994 (Delhi); Bharati Sadasivam, "Uteri Surgery sparks debate on Medical Ethics", *The Times of India*, 10 Feb.1994 (Delhi).

31. Suresh Deshpande, President of the Indian Medical Association, Pune as quoted by Arshia Sattar, "The Blood of Others", *The Sunday Times of India Review*, 20 Feb. 1994 (Delhi).

just, fair and reasonable. Judicial pronouncements have also stressed that the deprivation should not be greater than necessary. The less restrictive alternative has to be preferred.

The hysterectomy operations infringed the right to life of women with mental handicap. The performance of operations on the inmates of a state institution could only occur if sanctioned by a constitutionally consonant statutory procedure. No such procedure is in place.

A constitutionally consonant procedure would require recognition of the range of capacities of women with mental handicap and their ability to take care and decide for themselves. Just a mental handicap labelling would not operate as sufficient justification for the state to take life denying decisions. In such procedure the criteria which justify such operations would need to be specified. Any purpose which could be achieved through less drastic means would necessarily not qualify for inclusion. Hygiene surely can be maintained by training the inmate to take care of herself, attendant support and a regular supply of napkins and tampons.

As it stands, the performance of the operations is an aggrandisement of illegitimate power by the state and a blatant violation of human rights of persons with mental handicap.[32]

VI Conclusion and suggestions

An unproblematic approach to a problematic issue does not solve the problem but renders its solution non-existent. Arrogation of decision making power for the minor with mental disability by the state or its allocation to guardians may be expedient, but is not just.

According to the Convention on the Rights of the Child 1989 a just legal order on mental health would require that decisions on mental health care and treatment of a minor are arrived at with the integral involvement of the minor. Participation thus needs to be the norm and surrogacy the exception. In recognition of this shift of emphasis article 12 of the Convention requires that "state parties shall assure to the child who is capable of forming his or her own view the right to express those views freely in all matters affecting the child the views of the child being given due weight in accordance with the age and maturity of the child."

Article 25 of the Convention recognises "the right of a child who has been placed by the competent authorities, for the purposes of care, protection, or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement."

The need for adequate representation for the views of the minor has also been conceded by the U.N. Principles for the "Protection of Persons with Mental

32. See, A. Dhanda, "Hysterectomies-Constitutional Constraints on State Power", 11(1) *Samadhan News* 3 (Jan.-Mar. 1994).

Illness and for the Improvement of Mental Health Care". Principle 2 requires "special care" to be taken "to protect the rights of minors including if necessary the appointment of a personal representative other than a family member."

The desiderata in international instruments have been enunciated whilst recognising that the protection-autonomy divide could be variantly resolved in domestic law. The instruments can thus be usefully employed to dismantle the unproblematic legal order on mental health treatment of minors and to promote the formulation of a child friendly mental health law.

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