

LAW REFORM
COMMISSION/COIMISIÚN UM
ATHCHÓIRIÚ AN DLÍ

CONSULTATION PAPER

CHILDREN AND THE LAW: MEDICAL TREATMENT

(LRC CP 59-2009)

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Law Reform Commission

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INTRODUCTION

A Background to this Project

1. This Consultation Paper forms part of the Commission's *Third Programme of Law Reform 2008-2014*¹ and involves examination of the law concerning medical treatment as it applies to children, that is, persons under the age of 18.

2. The project involves a continuation of the Commission's long-standing work on reform of the law concerning children. This has included the Commission's 1983 *Report on the Age of Majority*² in which the Commission recommended that the general age of majority – the age at which a person is regarded as an adult for many purposes - should be reduced from 21 to 18. This was implemented in the *Age of Majority Act 1985*. While the Commission discusses in this Consultation Paper whether persons under the age of 18 may be regarded as being capable of consenting to, or refusing, medical treatment, the proposals made do not involve a general reduction in the age of majority.

3. Because this project involves an examination of capacity to consent to, and to refuse, medical treatment, it also complements the Commission's more recent work on the law concerning mental capacity as it applies to persons over 18 years of age. This work culminated in the Commission's 2006 *Report on Vulnerable Adults and the Law*³ and the 2009 *Report on Bioethics: Advance Care Directives*.⁴ The Commission anticipates that this work will be incorporated into the Government's proposed *Mental Capacity Bill*, in respect of which the *Scheme of a Mental Capacity Bill 2008* was published in September 2008.⁵

4. The Commission now turns to provide a brief overview of the Consultation Paper.

¹ *Report on the Third Programme of Law Reform 2008-2014* (LRC 86-2007) Project 26, which commits the Commission to examine aspects of the law concerning children, including consent to medical treatment.

² LRC 5-1983.

³ LRC 83-2006.

⁴ LRC 94-2009.

⁵ The scheme of the 2008 Bill is available at www.justice.ie. See also *Report on Bioethics: Advance Care Directives* (LRC 94-2009), Introduction, paragraph 1.

B Outline of this Consultation Paper

5. In Chapter 1, the Commission examines the rights of children of relevance to this project. These include the rights of children recognised under the Constitution of Ireland and under international Conventions and other similar documents. The Chapter begins with an explanation of the terminology used throughout the Consultation Paper to refer to children of different ages. The Commission examines the rights of the child under the Constitution, and then focuses on these rights in a medical context. The Commission also examines the rights of the child under international law, particularly under the 1989 United Nations Convention on the Rights of the Child. The chapter concludes with a focus on the voice of the child and contains findings from a consultation carried out by the Commission with children and young people. This was carried out with the invaluable assistance of the Ombudsman for Children's Office.

6. In Chapter 2, the Commission discusses the recognition that a child develops on gradual basis towards being an adult, or from being a minor to achieving the age of majority. The Chapter contains an account of the law relating to minority status and highlights the importance of reviewing different ages of consent in line with societal developments and the evolving capacity of children and adolescents. The Chapter then discusses the guiding principles which underpin the creation of different age limits and ages of consent for different purposes. The Commission also discusses the historical development of ages of majority up to the enactment of the *Age of Majority Act 1985*. This also includes a description of the legal rights and responsibilities of those under 18 years in current law.

7. In Chapter 3, the Commission discusses the extent to which it is possible to define the term "medical treatment" and associated wider terms such as "health care" in the specific context of treatment involving persons under 18 years of age. As the Commission notes in this chapter, there is currently no single all-purpose definition of these terms, reflecting their potentially wide-ranging scope of application and the ongoing use and development of new technologies and procedures in health care and medical practice. The Commission discusses the different uses of the term "medical treatment" currently in use in Irish law and also developments that have occurred in this respect in other countries. The chapter also explores the medical concerns of Irish children and young people in order to consider the types of treatments which are most important to them and their continuing development. The Commission then discusses how the issue of consent to medical treatment has arisen in many countries in the specific context of the provision of contraceptive advice and treatment to improve sexual health. The Commission completes this analysis with a number of general proposals on consent to treatment.

8. In Chapter 4, the Commission discusses the current legal situation in relation to children and consent to medical treatment. The chapter begins by examining the relevant position under Irish law, including the relevance of section 23 of the *Non-Fatal Offences Against the Person Act 1997*, which deals with consent to treatment by 16 and 17-year-olds. The Chapter concludes with the Commission's provisional recommendations on this area.

9. In Chapter 5, the Commission turns to examine refusal of medical treatment. The Commission examines Irish law on refusal of medical treatment, on which much of the material is limited to refusal by an adult. The Commission then addresses the issues raised by refusal of medical treatment by a person under 18, including a comparative analysis of the position in other countries. The Commission completes this chapter with proposals for reform, and also addresses the question of advance care directives for persons under 18 years of age.

10. In Chapter 6, the Commission discusses medical services and legislation in relation to children and young people with mental health problems. The Commission reviews the literature on the prevalence of mental health problems among children and adolescents in Ireland. The Commission then examines current service provision and the impact of the *Mental Health Act 2001* on patients under the age of 18. The chapter concludes with the Commission's provisional recommendations for reform.

11. Chapter 7 contains a summary of the provisional recommendations made in the Consultation Paper.

12. The Appendix comprises a map indicating some key steps in the analysis of capacity to consent to and refuse health care and medical treatment for persons under 18.

13. This Consultation Paper is intended to form the basis of discussion and therefore all the recommendations made are provisional in nature. The Commission will make its final recommendations on the subject of children and medical treatment following further consideration of the issues and further consultation with interested parties. Submissions on the provisional recommendations included in this Consultation Paper are welcome. To enable the Commission to proceed with the preparation of its final Report, those who wish to do so are requested to make their submissions in writing by post to the Commission or by email to info@lawreform.ie by **31 March 2010**.

CHAPTER 1 RIGHTS OF THE CHILD

A Introduction

1.01 This Chapter discusses the rights of the child. Part B briefly explains the terminology used throughout the Consultation Paper to refer to children of different ages. Part C examines the rights of the child under the Constitution. Part D looks at the personal rights of children in a medical context. Part E contains a discussion of the rights of the child under international law, particularly under the Convention on the Rights of the Child 1989. Part F concludes with a focus on the voice of the child and contains findings from a consultation carried out by the Commission with children and young people.

B Terminology

1.02 A child is defined as a person under 18 years of age.¹ There are numerous words and labels however which arise during a discussion on the rights and capacities of children, for example, infant, child, teenager, minor, mature minor, adolescent, young person and so on. *The Children Act 1908* used the term 'infant', which has been replaced by the term 'child' in more recent legislation, such as the *Child Care Act 1991*. The term 'young person' is frequently used in common discourse to differentiate between a child and an older adolescent. The term is also in use in statutory form, in the *Protection of Young Persons Employment Act 1996*. For the purposes of this consultation paper, the terms 'children' and 'young people' shall be used to distinguish older adolescents from young children. The terms children and young people are used in other countries to recognise the different capacities of, for example, a 6

¹ Article 1 of the Convention on the Rights of the Child 1989 defines a child as every human being below the age of 18 years unless under the law applicable to the child majority is achieved earlier. Section 2 of the *Age of Majority Act 1985* defines a minor as a person under the age of 18 years who is not or has not been married. Section 21 of the *Interpretation Act 2005* defines 'full age' as "the time when the person attains the age of 18 years or sooner marries, or any time after either event"

year old and a 16 year old. Various law reform bodies which have examined issues of age and status have also used this terminology.²

1.03 It is difficult to define precisely the age groups of children that the term child or young person should apply. Issues of capacity, maturity, understanding, appreciation and experience cannot be resolved by reference to a fixed age. Generally speaking, the Commission has used the term child in relation to a person aged up to 16 years of age, and the term young person to describe a person aged 16 years or over. These age distinctions are, however, intended to be used in a flexible manner, to accommodate particular cases and circumstances. Furthermore, this terminology applies only to the particular issue under review, namely the age of consent to medical treatment.

C Rights of the Child under the Constitution

1.04 The Constitution is the fundamental law of the State. It is the primary source of principles, rights and ideals against which all legislation and case law must be measured. Any assessment of children's rights and responsibilities must be carried out in light of the constitutional protection of the family and the strong emphasis on the family unit and parental rights enshrined in Articles 41 and 42 of the Constitution.³

1.05 Articles 41 and 42 set out the irrefutable constitutional position of the family as:

“the natural primary and fundamental unit group of Society and as a moral institution possessing inalienable and imprescriptible rights, antecedent and superior to all positive law.”

Article 42 deals with the relationship between State and family and also sets out the position of the child within the family:

“In exceptional cases, where parents for physical or moral reasons fail in their duty towards their children, the State as guardian of the common good, by appropriate means shall endeavour to supply the place of the parents, but always with due regard for the natural and imprescriptible rights of the child.”

² New South Wales Law Reform Commission *Minors Consent to Medical Treatment* (Issues Paper 24 2004) at 16. Queensland Law Reform Commission *Consent to Medical Treatment of Young People* (Discussion Paper 44 1995) at 6.

³ See discussion in Shannon *Child Law* (Thompson Roundhall 2005) at 3, Shatter *Shatter's Family Law* (4th ed Tottel Publishing 1997) at 5, Kilkelly *Children's Rights in Ireland* (Tottel Publishing 2008) at 61.

1.06 A significant line of cases have centred on the applicable test in cases of failure of parental duty.⁴ The non-interventionist stance which has developed from Article 42 has become a focal point for debate and dissatisfaction with the seemingly impenetrable position of the marital family. The rights of the family are exercised by parents, as head of the protected and autonomous family unit. As Article 42 provides the sole express reference to the rights of the child in the Constitution, this creates an assumption of correlation between the rights and wishes of the parent, and those of the child.⁵ The absence of express constitutional rights for children has been viewed as confirmation of such an assumption, and various calls have been made to improve the position of the child in the Constitution.

1.07 Looking beyond Article 42, however, every child has a broad set of personal and unremunerated rights protected by Article 40.3.⁶ Several cases have focused on the scope of rights held by children, in particular *G v An Bord Uachtala 1980*⁷. To quote Walsh J:

“The Child’s natural rights spring primarily from the natural right of every individual to life, to be reared and educated, to liberty, to work, to rest and recreation, to the practice of religion, and to follow his or her conscience..... The child’s natural right to life and all that flows from that right are independent of any right of the parent as such”⁸

O Higgins CJ stated that:

“The Child has the right to be fed and to live, to be reared and educated, to have the opportunity of working and realising his or her full personality and dignity as a human being. The rights of the child

⁴ *N & Anor v HSE & Ors* [2006] IESC 60, *North Western Health Board v HW & CW* [2001] 3 IR 622, *Re JH (An Infant)* [1985] IR 375 .

⁵ See Carolan “The Constitutional Consequences of Reform: Best interests after the Amendment” (2007) 10(3) *Irish Journal of Family Law* at 3, Kilkelly *Children’s Rights in Ireland* (Tottel Publishing 2008) at 61.

⁶ Article 40.3 “The State guarantees in its laws to respect, and, as far as is practicable, by its laws to defend and vindicate the personal rights of the citizen”. *G v An Bord Uachtala* [1980] IR 32, *In the matter of Article 26 and the Adoption (No.2) Bill 1987* [1989] IR 656.

⁷ [1980] IR 32

⁸ *G v An Bord Uchtála* [1980] IR 32 at 69.

(and others which I have not enumerated) must equally be protected and vindicated by the State”⁹

1.08 This is an explicit acknowledgment that children are beneficiaries of a wide range of personal rights, just as adults are. A child has a right to privacy, bodily integrity, good health, dignity and self-determination, and the State has a duty to respect and as far as practicable, vindicate such rights. It is clear that a child has personal rights under the Constitution however the Constitution’s view of the child has been likened to a Kantian or Lockean view of the child as a being who has not yet attained reason and as such is not capable of self-determination.¹⁰ This position is at odds with the developing notion of parental responsibility as opposed to parental rights, and the growing international awareness of children as autonomous holders of rights.¹¹

1.09 The constitutional rights of children and young people arose in a case concerning a 17 year old’s right to travel, which was heard in the High Court in May 2007.¹² The 17 year old female, Ms D, sought a number of orders to set aside a Care Order, in so far as the Care Order restricted her right to travel. Ms D intended to travel to England with the purpose of terminating her pregnancy, but had been prevented from doing so by the Health Service Executive (HSE).

1.10 Mc Kenchie J held that there was no statutory or constitutional impediment which would prevent Ms D from travelling to the United Kingdom for the purposes of terminating her pregnancy, if she so wishes. The crux of the case was the right to travel. The fact that the purpose of travel was to terminate a pregnancy did not convert the case into one of abortion case. Moreover, the right to travel, as constitutionally guaranteed, takes precedence over any exercise of rights conferred on the unborn within Article 40.3.3 of the Constitution.¹³

1.11 Mc Kechnie J stated that Ms D was not an irresponsible child, but a person of maturity, courage, dignity and integrity. In relation to the rights of the child:

⁹ *Ibid* at 56.

¹⁰ Tomkin & Hanafin *Irish Medical Law* (Round Hall Sweet and Maxwell 1995) at 41.

¹¹ Arthur “North Western Health Board v. H.W. and C.W- Reformulating Irish Family Law” (2002) 5(1) *Irish Journal of Family Law* 39 at 39.

¹² *D v Attorney General* High Court 9 May 2007.

¹³ Article 40.3.3 “This subsection shall not limit freedom to travel between the State and another State.”

“It is imperative to recognise that children are born with rights and those rights continue right throughout childhood into teenage years and become unaffected in their entirety by the parental relationship on reaching majority.”

1.12 Although these rights are originally exercised on behalf of children, usually by their parents, the rights remain the rights of the child and commensurate with the progressive development and maturity of such a child. *Mc Kechnie J* referred to the various age thresholds set out by the law to allow for the gradual assumption of rights and responsibilities during childhood and adolescence.

“...age, short of majority, is not the conclusive test or threshold but it is important in its own right and becomes increasingly so as full status appears more imminent.”

1.13 Although parental rights are clearly much stronger than the rights of the HSE in relation to a child in care; *Mc Kechnie J*, referring to judgments by Lord Denning in *Hewer v Bryant*¹⁴ and Lord Scarman in *Gillick*¹⁵, suggested that a conflict in relation to the rights of the parent and the rights of the child would not have led to a different conclusion in the present case. Ms D was exercising her own constitutional rights and assuming her own constitutional responsibilities.

1.14 This judgement, although largely concerned with the constitutional right to travel is of general importance for the rights of the child. The judgment provides a clear affirmation of the personal rights held by children under the Constitution. The reference to the *Hewer* and *Gillick* cases indicate an awareness of the evolving capacity of children, and the legal capacity of a child to exercise his or her constitutional right as he or she grows older and matures.

¹⁴ *Hewer v Bryant* [1970] 1 Q.B. 357. Lord Denning “The common law can, and should, keep pace with the times...the legal right of a parent to the custody of a child ends at the 18th birthday; and even up till then, it is a dwindling right which the courts will hesitate to enforce against the wishes of the child, and the more so the older he is. It starts with a right of control and ends with little more than advice”.

¹⁵ *Gillick v West Norfolk and Wisbech Health Authority* [1985] 3 All ER 402. The case is discussed further in chapter 3 at paragraph 3.82.

D Children's Rights in the Context of Medical Law

1.15 A constitutional right to the protection of one's health has been identified by the Supreme Court.¹⁶ Personal rights of bodily integrity, autonomy, dignity and privacy must be respected in the medical sphere. Such rights are not curtailed or limited by age or minor status. Binchy writing on the constitutional right to dignity, has stressed that the Constitution ascribes equal worth to every human being, regardless of his or her age or physical or mental capacity.¹⁷

1.16 There is little judicial authority on the rights of a child in a medical context and the courts have yet to address the question of whether a child's personal rights, and capacity to make a decision, could take precedence over a parent's decision. The case of *North Western Health Board v HW*¹⁸, referred to below, provides a detailed assessment of the constitutional rights of parents to make medical decisions on behalf of their children, but is not directly applicable to a discussion of a child's capacity to make medical decisions. The child at the centre of the case was very young and the dispute was in effect, between the child's parents and the State.

1.17 The case of *North Western Health Board v HW* was based on the refusal of parents to consent to a diagnostic test on behalf of their young child. The Supreme Court ruled that the welfare of a child is best served by deferring health care decisions to a child's parents and the court could only intervene in exceptional circumstances.¹⁹ Although the medical test in question was held to be in the child's best interests, this factor alone was not sufficient to establish parental failure. In the words of Murray J:

"The failure of the parental duty which would justify and compel intervention by the State must be exceptional indeed"²⁰

1.18 Denham J referred briefly to the rights of the child stating:

¹⁶ *Ryan v AG* [1965] IR 294. See discussion in Madden *Medicine, Ethics and the Law* (Butterworths 2002) at 56.

¹⁷ Binchy "Dignity as a Constitutional Concept" in Doyle & Carolan (eds) *The Irish Constitution: Governance and Values* (Thompson Round Hall 2008) at 324.

¹⁸ [2001] 3 IR 622.

¹⁹ Mills *Clinical Practice and the Law* (2nd ed Tottel Publishing 2007) at 81.

²⁰ *North Western Health Board v HW & CW* [2001] IR 622.

“The rights of the parents in exercising their responsibility are not absolute; the child has personal constitutional rights. The child has rights both as part of the unit of the family and as an individual.”²¹

1.19 A point to note is that the dispute centred on a diagnostic test, as opposed to a specific treatment which would improve the child’s health. The courts have yet to explore any circumstances involving a dispute between a child and parent regarding a medical decision. The capacity of the child to consent to medical treatment would be a vital factor in any such case. Consent is a fundamental cornerstone of medical law, and is an expression of respect for personal rights of autonomy and self-determination.

Autonomy and Informed Consent

1.20 The notion of individual autonomy is based on the autonomous person who is a self-determining agent, with responsibility for one’s own actions and decisions.

“Over himself, over his own mind and body, the individual is sovereign.”²²

1.21 Autonomy, based on the idea that our decisions and actions are ours alone, is the basis for consent, and refusal. Respect for autonomy encompasses respect and recognition for the decisions that each person makes in valuing and defining his or her life²³. Dworkin maintains that there is something special about the role of autonomy in relation to health care and medical decisions. A doctor cares for the health of the body however the care of the body is intrinsically linked with our identity as persons.²⁴ A classic expression of the law’s respect for the autonomy of the individual is found in the statement by Cardozo J:

Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without the patient’s consent commits an assault²⁵

²¹ *Ibid* at 718.

²² J.S. Mill *On Liberty* in *Utilitarianism, Liberty and Representative Government* (J.M. Dent, 1960).

²³ Madden *Medicine, Ethics & the Law* (Butterworths 2002) at 394.

²⁴ Dworkin *The Theory and Practice of Autonomy* (Cambridge University Press 1988) at 112.

²⁵ *Schloendorff v Society of New York Hospital* (1914)105 NE 92.

1.22 The requirement of consent is an expression of respect for individual autonomy and has been endorsed as an essential pre-requisite to any medical treatment by common law, and the principles developed through medical ethics and human rights.²⁶ The Supreme Court has stated that:

“The requirement of consent to medical treatment is an aspect of a person’s right to bodily integrity under Article 40.3 of the Constitution”.²⁷

1.23 Autonomy is based on respect for the individual’s decisions, whether they are deemed to be right or wrong, positive or negative. The right to self-determination encompasses both the right to consent and the right to refuse medical treatment. It is the act of decision making which demands respect, not the consequence.

1.24 The prerequisite factor of capacity underpins the notion of consent and acts as a limit to the right of autonomy.²⁸ In brief, capacity to give a legally effective consent is dependent upon capacity to understand the issue at hand and reach a decision.²⁹

1.25 Much of the legal protection concerning the right of autonomy presumes that the patient is an adult with full mental capabilities. There is however, a growing awareness that members of society who have been deemed as lacking in capacity have recognised rights which are worthy of respect and protection. There has been an implicit rejection of the traditional protectionist approach to capacity and a move towards an inclusive scheme based on the dignity of the human being and an emphasis on autonomy and empowerment.³⁰ Rights of privacy, bodily integrity, dignity and freedom from inhuman and degrading treatment are not diminished by a finding of legal

²⁶ Sheikh “Editorial: Issues of Capacity and Consent” (2008) 14(2) *Medico Legal Journal of Ireland* (2008) at 30.

²⁷ *Re a Ward of Court (withholding medical treatment) (No.2)* [1996] 2 IR 79 at 156.

²⁸ See Donnelly “The Right of Autonomy in Irish Law” (2008) *Medico Legal Journal of Ireland* 14(2) 34 at 34.

²⁹ For a detailed discussion on capacity see Law Reform Commission *Vulnerable Adults and the Law* (CP 37-2005) at paragraphs 2.27 -2.40.

³⁰ Law Reform Commission *Vulnerable Adults and the Law* (CP 37-2005) at paragraph 1.20, Donnelly “Legislating for Incapacity: Developing a Rights-Based Framework” (2008) 15(1) *Dublin University Law Journal* 395 at 400.

incapacity.³¹ Those deemed to be lacking in capacity have legally enforceable rights under the Constitution and the European Convention on Human Rights.³²

1.26 The right to be informed is a central aspect of the right to consent to medical treatment. A person may lack the capacity to make a particular decision but he or she may have an important contribution to make to the decision-making process and has a right to ensure that his or her contribution is taken into account in medical decisions which affect his or her health.³³

1.27 This is particularly important for children. Children may not have the capacity to consent to medical treatment, but they have a right to express their opinions and to be informed about their medical condition and treatment. It is not always suitable to inform children, particularly those at a very young age, of all the pertaining facts. A child's right to personal information, however, should not be disregarded simply because he or she lacks the legal capacity to make decisions regarding medical treatment.

“It can be argued that it is overly simplistic to view the duty to disclose as being directed towards the person who has legal capacity to consent and not to include the actual person within the ambit of the duty”.³⁴

1.28 The Law Society of Ireland's Law Reform Committee has highlighted the importance of recognising the different stages of maturity and development throughout childhood:

“The consultation of children recognises their importance and personal autonomy, and can promote their decision-making capacities without saddling them with the final responsibility for decisions they should not have to have the responsibility of making”³⁵

1.29 Although a child may lack capacity to consent to treatment, informing the child and obtaining consent from the child is considered to be best practice

³¹ Donnelly “Legislating for Incapacity: Developing a Rights-Based Framework” (2008) 15(1) *Dublin University Law Journal* 395 at 400, Law Reform Commission *Vulnerable Adults and the Law* (CP 37-2005) at paragraph 1.27.

³² Donnelly “Legislating for Incapacity: Developing a Rights-Based Framework” (2008) 15(1) *Dublin University Law Journal* 395 at 399.

³³ Kilkelly & Donnelly *The Child's Right to be Heard in the Healthcare Setting* (Office of the Minister for Children 2006) at 6.

³⁴ *Ibid* at 27.

³⁵ Law Society's Law Reform Committee *Rights-based Child Law: The Case for Reform* (Law Society of Ireland 2006) at 9.

by many health professionals. A relationship built on consent and understanding is essential to respect the autonomy of children and their right to bodily integrity.³⁶

1.30 The issue of informed consent in such a context has not been discussed in any detail before the courts, but was briefly referred to in the case of *Quinn v The Southern Eastern Health Board*.³⁷ O' Caoimh J held that consent given by a 14 year old girl to a neurological procedure was not informed, due to the fact that neither the girl nor her parents had been told of the risks associated with the procedure. The fact that the patient was not advised appropriately of the consequences of the procedure seemed to be a determining factor. This indicates that the plaintiff, as a 14 year old, had a right to be informed.³⁸

1.31 The issue in *N. McK v Information Commissioner*³⁹ was the applicable test under the *Freedom of Information Act 1997* regarding a parent's access to the personal information of his child. The applicant was a widower who had been separated from his wife and was joint guardian of his daughter, along with his sister in law, with whom his daughter lived. Following an allegation that he had sexually abused his daughter, Mr Mc K was granted supervised access to his daughter.

1.32 Mr Mc K sought access to his daughter's medical records. According to regulations, a minor's personal information may be released to the minor's parent or guardian, where it is in the minor's best interests. The Information Commissioner, in agreement with an earlier decision made by a hospital, refused the applicant's request on the grounds that it was not in the best interests of his daughter. The applicant successfully appealed the decision of the Information Commissioner to the High Court, where Quirke J relied on the Supreme Court decision in *North Western Health Board v HW 2001* and held that there is a presumption of parental entitlement to a child's personal information. The approach taken by the Information Commissioner, that the applicant should show that access to the information was in the child's best interests, was incorrect. The Supreme Court affirmed the decision of the High Court and stated that the Information Commissioner should have approached the request for information by acknowledging that the applicant was entitled to

³⁶ Kilkelly & Donnelly *The Child's Right to be Heard in the Healthcare Setting* (Office of the Minister for Children) 2006 at 22.

³⁷ [2002] IEHC 43.

³⁸ *Quinn v The South Eastern Health Board* [2002] IEHC 43, Kilkelly & Donnelly *The Child's Right to be Heard in the Healthcare Setting* (Office of the Minister for Children) 2006 at 27.

³⁹ [2004] 1IR 12.

the information, before considering any evidence which could rebut the presumption of parental entitlement to a child's personal information.⁴⁰

1.33 By the time the case reached the Supreme Court, the minor in question was almost 18 years of age. There was, however, no reference to the minor's wishes or to the fact that the minor was, under section 23 of the *Non-Fatal Offences Against the Person Act 1997*, capable of consenting to medical treatment in her own right.⁴¹ The single judgment, delivered by Denham J, referred to the age of the minor and stated that her views are "now very relevant". There was no further discussion, as the matter reverted to the Information Commissioner to reconsider the request in light of the Supreme Court judgment.

1.34 The Information Commissioner reconsidered the matter and reached the conclusion that the presumption of parental entitlement to a child's information was rebutted by direct evidence put forward by the applicant's daughter, Ms Mc K. The Commissioner had regard to the age and maturity of Ms Mc K and the cogent reasons she advanced in relation to her views.⁴² The Commissioner also referred to section 23 of the *Non-Fatal Offences Against the Person Act 1997* as recognition by the Oireachtas that minors aged 16 years of age have the capacity to determine what is in their best interests in the context of medical treatment. The decision of the Information Commissioner has not been appealed to the High Court.

E Rights of the Child under International Law

1.35 A large body of international human rights law exists today which can be used to influence the progression of human rights ideals into concrete principles of domestic law. When examining various national and international human rights instruments, one can identify a discernable emphasis on the rights of the child.⁴³ These legal instruments recognise the dependency and

⁴⁰ *N. McK v Information Commissioner* [2006] IR 260.

⁴¹ See 4.02.

⁴² Ms K had not spoken to her father for a number of years before the request for information and contact with her father caused her stress and anxiety. She viewed the request as an attack on her privacy and did not believe disclosure of the information would be in her best interests.

⁴³ Articles 25 and 26 Universal Declaration of Human Rights 1948, Articles 10, 12, 13 & 14 International Covenant on Economic, Social and Cultural Rights 1966, Articles 6(5) 10 14 17 18 23 and 24 International Covenant on Civil and Political Rights 1966, Articles 5 6 and 8 European Convention on Human Rights 1950 Articles 18 and 27 African Charter on Human and Peoples Rights 1981.

vulnerability of children, but also acknowledge that children's rights are a self standing matter and not a consequence or a derivative of the rights of their parents. Children as human beings are entitled to more than a minimum level of care and protection provided by their families. They are also entitled to participate in decisions involving their own futures. The process of securing rights and entitlements for children all over the world has been largely due to international human rights instruments which have recognised children as individual rights holders in addition to rights held collectively by a family unit.

(1) Convention on the Rights of the Child 1989

1.36 The UN Convention on the Rights of the Child 1989 is the most highly ratified human rights instrument in international law. The Convention covers a range of civil, political, economic, social and cultural rights and is a comprehensive declaration of the indivisibility of human rights. The actual number of substantive rights contained in the Convention makes it the longest United Nations human rights treaty in force.⁴⁴ The rights can be condensed into four categories: the participation of children in decisions affecting their future, the protection of children against discrimination, neglect and exploitation, the prevention of harm to children and the provision of assistance for their basic needs. The inclusion of social welfare rights shows the need for States to do more than protect children physically.

1.37 The Convention strives to achieve a balance between participation and protection, by treating children as dependants, reliant on the protection of adults whilst simultaneously acknowledging their right to participate in decisions affecting them.⁴⁵ Article 5 of the Convention reads:

“State Parties shall respect the responsibilities, rights and duties of parents... to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognised in the present Convention.”

1.38 Article 5 clearly respects the right and responsibility of parents to direct and guide their children, however this parental responsibility must be balanced with the rights of the child, by delivering guidance and direction in a child-centred manner. Parents and others have the responsibility to continually adjust the levels of support and guidance they offer to a child, effectively

⁴⁴ Van Buren *The International Law on the Rights of the Child* (Martinus Nijhoff 1995) at 16.

⁴⁵ Lucker-Babel “The right of the child to express views and be heard: An attempt to interpret Article 12 of the UN Convention on the rights of the Child” (1995) 3 *International Journal of Children's Rights* 391 at 397.

enabling children to participate more in the realisation of their rights. A General Comment issued by the Committee on the Rights of the Child in 2005 stated that parents and others should be encouraged to offer guidance in ways that enhance young children's capacities to exercise their rights, including their right to participation and freedom of thought, conscience and religion.⁴⁶

1.39 Article 12 outlines children's evolving capacity to exercise their rights and can be viewed as a compliment to Article 5:

"State Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all manners affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child."

1.40 Article 12 draws attention to the daily life of children and the decisions which affect them. A young child's rights will naturally be exercised by his or her parents, but as the child grows and matures the active participation by the child in the exercise of his or her rights becomes more and more important. As children evolve and grow, so too do their concerns, and the number and consequences of their decisions increase and diversify as they grow closer to reaching 18 years of age.⁴⁷ Participation by children is highly beneficial, as it enhances their communication and development skills and adds to the relationship between children and adults.

1.41 The relationship between the Article 3(1) and Article 12 of the Convention has attracted considerable debate. One of the guiding principles of interpretation of the Convention on the Rights of the Child is the principle of the best interests of the child, stated in Article 3 (1):

"In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration".⁴⁸

1.42 The principle has gained broad acceptance, is used in various other international instruments, and features prominently in debates and discourse on children's rights. It is important to note that an assessment of the best interests of a child should be informed by the views of the child, in accordance with

⁴⁶ Committee on the Rights of the Child "Implementing Child Rights in Early Childhood" (General Comment No 7 of 2005 CRC/C/GC/7 Rev 1) at 17.

⁴⁷ Lucker-Babel "The right of the child to express views and be heard: An attempt to interpret Article 12 of the UN Convention on the rights of the Child" (1995) 3 *International Journal of Children's Rights* 391 at 396.

⁴⁸ The best interests principle also features in Articles 9,18,20,21,37,40.

Article 12 of the Convention. Furthermore, the interpretation of best interests should be carried out from a holistic viewpoint, encompassing emotional as well as physical well-being.

1.43 On the surface the principle of best interests seems relatively self explanatory however this apparent simplicity is in direct contrast with the myriad of meanings attributed to it, as different commentators attempt to define what the interests of children are and what best serves their interests in different situations. Problems of indeterminacy and issues of cultural relativity are often associated with Article 3. Decisions on what course of action is in a child's best interests can be indeterminate, speculative and individualised.⁴⁹

1.44 In relation to cultural relativity, Van Buren commentated that the principle could become a fulcrum for regression rather than progression if States adopt a culturally relativist approach to defend their actions.⁵⁰ Open ended principles are at risk of being utilised in the defence of certain cultural practices which are harmful to children. Other commentators have viewed the principle of best interests as a way of ensuring greater openness and sensitivity to different cultural contexts in the implementation of human rights standards.⁵¹ Moreover, the Convention itself provides signposts as to how the principle should be applied to identify what is in the best interests of the child.⁵² General Comments issued by the Committee on the Rights of the Child also provide guidance to assist in the interpretation of individual articles.⁵³

1.45 Eekelaar has argued that a theory of 'dynamic self-determinism' which applies the best interests principle in a way which allows the child to determine what those interests are, resolves any potential tension between articles 3 and 12. The theory involves a reconstruction of the best interests principle, in that the perception of child's best interests should be formed in accordance with objective analysis and dynamic self-determinism. An objective analysis involves drawing on objective factors which indicate which conditions are deemed to be in the child's best interests, for example a prediction that the

⁴⁹ Thomas & O Kane "When Children's Wishes and Feelings Clash with their Best Interests" (1998) 6 *International Journal of Children's Rights* 137 at 138.

⁵⁰ Van Buren *The International Law on the Rights of the Child* (Martinus Nijhoff 1995) at 394.

⁵¹ Alston "The Best Interests Principle: Towards a Reconciliation of Culture and Human Rights"(1994) 8 *International Journal of Law & Family* 1 at 9.

⁵² *Ibid* at 19.

⁵³ The Committee on The Rights of the Child is a body of independent experts that monitors implementation of the Convention on the Rights of the Child 1989.

consequences of a child's non attendance at school will be adverse, or a belief that a child is better off living with her mother than with her father and a nanny.⁵⁴ Such 'objective' decisions are largely dependent on social consensus, where such consensus exists. The outcomes of these decisions are dependent on a range of variables, such as the personality of the child, the circumstances of the case and so on.

1.46 The additional element of dynamic self-determinism supplements the judgement of a child's best interests. This involves placing the child in a secure environment, but exposing the child to a range of influences, allowing the child to draw on these influences in such a way that the child himself or herself contributes to the outcome, creating space for self-development. The process is dynamic because it acknowledges that the best course for a child cannot always be realised at the time of the decision, and may need to be revised as the child grows up. For example, in a custody case, the directions in which the child's relationships may grow are left open, but a welfare professional can monitor changes in the family dynamics and assess the child's wishes and reaction to certain developments. Such an approach reflects the reality of family relationships and an appreciation that following parental separation, children are at risk of losing contact with a parent and that parent's kin network.

1.47 Children's decisions may, however, be contrary to their own interests, as desires and interests do not always correspond. Drawing on the thinking of Raz, Eekelaar states that if the child's self interest would be threatened by following self-determinism, it should be disapplied because the very purpose of dynamic self-determinism is to bring a child to the threshold of adulthood with maximum opportunities to form and pursue life-goals which reflect as closely as possible an autonomous choice. This leaves open the question of what exactly self-interest is and who defines it. Eekellar promotes a narrow definition of self-interest, in terms of physical or mental well-being and integrity. Such a definition is, however, open to personal interpretation.

1.48 It is important to remember that Article 12 is concerned with rights of participation, not rights of control.⁵⁵ Any attempt to assess what course of action is in the best interests of the child must be informed by the views of the child, however the child is not granted the final say on what is in his or her best interests. Dynamic self-determinism does not simply state that decisions are delegated to the child – rather, the theory aims to establish the most propitious

⁵⁴ Eekelaar "The Interests of the Child and the Child's Wishes: The Role of Dynamic Self-Determinism" (1994) 8(1) *International Journal of Law Policy & Family* 42 at 47.

⁵⁵ Thomas & O Kane "When Children's Wishes and Feelings Clash with their Best Interests" (1998) 6 *International Journal of Children's Rights* 137 at 150.

environment for the child to develop his or her personality. Unless the child is competent there is no question of the child's opinion being determinative. Furthermore, a child's decision could be deemed incompetent if it reflects a feeling which is so seriously unstable or where there is such grave disjunction between it and others held by the individual that to give effect to the decision risks serious conflict within the individual at a later stage. Freeman has espoused this view, calling for less emphasis on knowledge and understanding and more emphasis on how the decision of a child or a young person furthers their well being and corresponds with their system of values.⁵⁶

1.49 The General Comment on the *Right of the Child to Be Heard* issued by the Committee on the Rights of the Child in 2009 referred to the complementary interaction between Articles 3 and 12 of the Convention.⁵⁷ Article 3 establishes the objective of achieving the best interests of the child and Article 12 provides the methodology for hearing the child. There can be no correct application of Article 3 if the components of Article 12 are not respected. Article 3 in turn reinforces the functionality of Article 12, facilitating the essential role of children in all decisions which affect them.

1.50 Article 12 is particularly relevant in the health care setting where increased participation and understanding by patients is closely associated with positive treatment results. Article 24 of the Convention deals specifically with rights of the child in the context of health care:

“State Parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. State parties shall strive to ensure that no child is deprived of his or her right of access to such health care services”

1.51 Article 12 focuses on consultation and consideration of the child's opinion rather than direct or immediate implementation. The implications of Article 12 are that children have the right to be listened to by health professionals during consultation, investigation and treatment, even where the law does not require their legal consent. The General Comment on the *Right of the Child to be Heard*, clearly stated that Article 12 must be allocated a place of respect and deference within the medical arena:

“The realisation of the provisions of the Convention requires respect for the child's right to express his or her views and to participate in

⁵⁶ Freeman, “Rethinking Gillick” (2005) 13 *International Journal of Children's Rights* 201 at 213.

⁵⁷ Committee on the Rights of the Child “The Right of the Child to be Heard” (General Comment No.12 of 2009 CRC/C/GC/12) at 70.

promoting the healthy development and well-being of children. This applies to individual health-care decisions, as well as to children's involvement in the development of health policy and services."⁵⁸

1.52 The Committee on the Rights of the Child is a body of independent experts that monitors implementation of the Convention on the Rights of the Child 1989. In 2006, the Committee considered Ireland's second report on implementation of the Convention on the Rights of the Child.⁵⁹ The Committee expressed concern that some of its previous recommendations had not been addressed, particularly those related to the status of the child as a rights-holder and the adoption of a child rights-based approach in policies and practices. In relation to Article 12 of the Convention, the Committee recommended that Ireland strengthen its efforts to ensure that children have the right to express their views in all matters affecting them and to have their views given due weight, in particular in families, educational institutions, the health sector and in communities.⁶⁰ Furthermore, children should be provided with the opportunity to be heard in judicial and administrative proceedings affecting them. In respect of health and health services, the Committee expressed concern over the lack of a comprehensive legal framework and the absence of statutory guidelines safeguarding the quality of and access to health care services as stipulated in Article 24 of the Convention.⁶¹

(2) European Convention on Human Rights 1950

1.53 The European Convention on Human Rights (ECHR) does not refer specifically to children but Article 1 states that the rights and freedoms outlined shall apply to everyone. Moreover, Article 14 prohibits discrimination in the enjoyment of Convention rights on various grounds, including age.⁶²

1.54 In 1979, the Parliamentary Assembly of the Council of Europe recommended drafting of a European Charter on the Rights of the Child. In 1990, the suggestion was omitted from proposals listed to promote children's

⁵⁸ Committee on the Rights of the Child "The Right of the Child to be Heard" (General Comment No.12 of 2009 CRC/C/GC/12) at 98.

⁵⁹ Concluding Observations of the Committee on the Rights of the Child: Ireland (CRC/C/IRLCO/2 29 September 2006).

⁶⁰ *Ibid* at 25.

⁶¹ *Ibid* at 44.

⁶² See Kilkelly "The Best of Both Worlds for Children's Rights? Interpreting the European Convention on Human Rights in the Light of the UN Convention on the Rights of the Child" (2001) 23 *Human Rights Quarterly* 308-326.

rights⁶³, perhaps as a recognition that it would achieve little more than mirroring the Convention on the Rights of the Child 1989. The focus on children, particularly their right to be heard under Article 12 of the Convention on the Rights of the Child, led to the adoption of the European Convention on the Exercise of Children's Rights by the Council of Europe in 1996. The Convention on the Exercise of Children's Rights 1996 states that the rights and best interests of children should be promoted. The Convention provides a mechanism for a child to participate in family law proceedings and emphasises that children should have an opportunity to exercise their rights.⁶⁴ Article 1(1) sets out the aim of the Convention:

“in the best interests of children, to promote their rights, to grant them procedural rights and to facilitate the exercise of these rights by ensuring that children are, themselves or through other persons or bodies, informed and allowed to participate in proceedings affecting them before a judicial authority”.

1.55 Regardless of the absence of a specific protocol on children's rights, the European Court of Human Rights (ECtHR) has made considerable progress in upholding the rights of the child by using innovative methods of interpretation and drawing on some of the provisions of the Convention of the Rights of the Child.⁶⁵ Many of the Articles of the ECHR are expressed in broad terms, allowing for expansive interpretation. Article 8, for example protects the right to private life and has been relied on in numerous cases concerning family and child law. It is clear that the approach of the ECtHR to the definition of family life is, much wider than the Irish courts' interpretations of Article 41 and offers greater opportunity to protect all family members, including children.⁶⁶ The ECtHR has stressed the right of the child to be heard in proceedings affecting him or her.

1.56 The status afforded to the voice of the child has been significantly enhanced by the Council of Europe Regulation on the recognition of judgments

⁶³ Parliamentary Assembly of the Council of Europe, Recommendation 1121 (1990) on the Rights of the Child. See Fortin *Children's Rights and the Developing Law* (2nd ed Butterworths 2003) at 64.

⁶⁴ Ireland has signed but not ratified the convention.

⁶⁵ Kilkelly “The Best of Both Worlds for Children's Rights? Interpreting the European Convention on Human Rights in Light of the UN Convention on the Rights of the Child” (2001) 23 *Human Rights Quarterly* 308 at 308.

⁶⁶ Kilkelly “Children's Rights: A European Perspective” (2004) *Judicial Studies Institute Journal* 68 at 95.

in family proceedings, Brussels II bis 2002.⁶⁷ The revised regulation provides that a court order will not be recognised in another EU member State if it was given without hearing the voice of the child. This requirement has strengthened the right of the child to be heard in family law proceedings and has made a significant difference to the status granted to the voice of the child in Irish courts.⁶⁸

1.57 Article 24 of the Charter of Fundamental Rights of the European Union, which forms part of EC law under the Lisbon Treaty recognises the rights of children to express their views and have their views considered in accordance with their age and maturity, in line with Article 12 of the Convention on the Rights of the Child 1989. The provision also states that the best interests of the child must be a primary concern, again drawing on the Convention on the Rights of the Child 1989.

1.58 Respect for the voice of the child in a medical context can be found in Article 6 of the Council of Europe 1997 Convention on Human Rights and Biomedicine. The Convention is an expression of the need to preserve human dignity, rights and freedoms from the misuse of biological and medical advances.⁶⁹ Article 6 provides for a representative to give consent where a minor does not have capacity, and states that the opinion of the minor shall be taken into consideration as an increasingly determining factor in proportion to his or her age and degree of maturity.

F Voice of the Child

1.59 In the Third Programme of Law Reform, the Commission stated its commitment to ensuring that the consultation process in relation to the project on Children and the Law would include mechanisms for obtaining the views of young persons. The Commission also stated that it would liaise with the Ombudsman for Children.⁷⁰

1.60 In order to obtain the views of children and young people, the Commission held a consultation day in the Office of the Ombudsman for Children. The aim of the consultation was to discuss various aspects of the law in relation to children and gain a practical insight into issues of consent and health care. At the outset, the participants made the point that the issues at

⁶⁷ Council Regulation (EC) No. 2001/2003 of 27 November 2003.

⁶⁸ See *M.N v R.N* [2009] 1 ILRM 431 where Finlay J held that the views of the 6 year old child involved should be ascertained.

⁶⁹ Ireland has not signed the convention.

⁷⁰ Law Reform Commission *Third Programme of Law Reform* (LRC 86-2007) at 26.

hand were complex, but trying to get clarity was in everyone's best interests - children, young people, their parents and the medical profession.

1.61 The following paragraphs are a summary of the main points made by children and young people in response to key questions.

1.62 ***Voice of the Young Patient***

1.63 The participants were very clear on the importance of explaining things to the child or young person, regardless of age:

“Clear explanation and information should be given in a manner appropriate to the child or young person. You should be treated as an individual and not talked over or sent out of the room. Try and strike a balance between the doctor, parent and child.”

1.64 ***Confidentiality***

1.65 Confidentiality is a significant concern for children and young people:

“Confidentiality should be respected regardless of age...although maybe it could be overridden if it was in the best interests of the patient. A person of 13 years and over should be guaranteed confidentiality.....a person of 16 years and over should be guaranteed confidentiality.....but it really depends on the situation, the health issue and the maturity of the person. Like a mental health condition might be really serious and the person would need help from their parents as well as a doctor.”

“Parental guidance is important for people under 16, like they might think they know it all but they don't because they don't really have much life experience”

“Consensus that parents want to know what's wrong - what's more important a parent knowing about their child's health or having an embarrassing conversation?”

“But what if lack of confidentiality stops a person from seeking medical advice? It depends on the sensitivity of the issue – if it's a sexual or mental health issue, there should be full confidentiality because the person might have feelings of guilt or shame and would want their confidentiality respected. Possible option - to have confidentiality respected and tell parents at a later stage when your ready to do so. So you could go to the doctor, get the information, think about it and then make a decision with your parents. Severity and type of illness is very relevant-like swine flu has implications for other people. So many exceptions and variety in different cases-might be better to leave the doctor with flexibility?”

“Need a balance between parents, child and doctor- not all the responsibility on the child –should be something in place where doctor might encourage a child to speak to an adult or their parents without breaking confidentiality-encourage discussion.”

1.66 ***Independence and Responsibility***

Do you or would you like to visit the doctor on your own? Would you like to take more responsibility for your health care?

1.67 Provision of information was held to be highly significant:

“Access to support and information is very important. There should be an option to visit attend medical services on your own, just for information. You could then have time to think about it and talk to your parents in your own time. Depending on the severity of the medical problem, may be the doctor could contact the parents or encourage the patient to tell his or her parents-but a doctor shouldn't make you tell your parents. If things were discussed more openly in general, it would be easier to ask your parents about things-but it's idealistic to expect parents to talk about things, the reality is they don't.”

“Practical considerations-money? Parents pay for the doctor so there is a limit to how independent young people can be. Personal experience is important, for example a child with diabetes needs to have control over their own body and deal with their illness. Your body - therefore you know your own needs. Actively responsible regarding your own knowledge and information, you have to keep yourself informed. Important to seek professional advice about something-and balance that against what's personally best for you.”

“Would allowing children more responsibility have a negative effect on the relationship with their parents? It depends on the nature of the relationship between the parent and child, is it good or bad, or is there trust and communication there? Lots of children and young people are afraid or embarrassed to talk to their parents but feel much better when they do, parents can reassure them and support them.

1.68 ***Refusal – The Case of Hannah Jones***⁷¹

1.69 The participants talked about the teenager Hannah Jones and her initial decision to refuse a heart transplant-followed by a change of mind some months later:

⁷¹ See discussion at 5.108.

“This case is exceptional - she had years of experience dealing with illness. Her parents gave her the option to decide - good to see that her parents well involved but she made the final call. Her story makes an abstract issue very real - makes you understand that she wanted to die with dignity. Her experiences added to her understanding - did her age really matter? Or should she just be looked upon as a person?”

1.70 **Age** - *as an indication of competence to consent to medical treatment. How important are different ages? Do different people mature at different ages? Is personal experience and knowledge more important than years?*

1.71 There was a general consensus that age and maturity are different:

“Age is important, but personal experience and maturity are also important. Age is a factor in an assessment of maturity for the majority of people but it depends on how you grew up and your experience.....a combination of age and maturity is needed to take certain issues into account. Factors such as the nature and seriousness of the medical decision, the personal experience of the patient, how informed the patient is, the time the patient has had to reflect on the decision, are all relevant. The opinion of someone who has a medical condition and is in hospital a lot should be taken more seriously”

“Age is an important guideline of someone’s maturity –but you have to look at the person and be realistic. Like just because the age of consent to sex is 17 – doesn’t mean everyone will wait until they’re 17”

1.72 When the participants began to think about an assessment of maturity in the context of medical treatment, they immediately began to draw up guidelines to assist in such an assessment:

- What is the nature of the medical decision?
- How serious is it?
- Does the patient understand the implications of the decision - both long and short term implications?
- Is the patient an informed patient?
- Does the patient’s decision concur with professional medical opinion on the issue?
- Is the treatment in the patient’s best interests (using a holistic interpretation of best interests, including happiness)?

1.73 ***Do you have any opinions on what age you should be able to consent to medical treatment?***

1.74 The participants had varying views on the weight which should be attached to age and maturity, but agreed that competency to consent should be based on both age and maturity.

“There shouldn’t be a cut off age because a cut age does exactly that - cuts people off. Consent to medical treatment should be assessed on the best interests of the patient. Need a combination of age and maturity. Difficult professional decisions – so the professionals need guidelines. Parents will be affected by their children’s health and decisions - but they don’t own their children.”

“12? 13? 16 as a flexible guide? 12 for girls and 13 for boys because girls mature faster - but would this raise equality issues? A person of any age should be able to get information but not everyone should be able to make treatment decisions. Involvement for everyone - informed consent - understanding is more important than a strict age rule. No age, it should be on a case by case basis like the mature minor rule. But is it unreasonable to put a burden on someone who’s very young? Maybe 16 - parents could have an opinion but the 16 year old could make the decision. What about 14 – if it was an informed decision, maybe weigh up child’s and parents opinions - what if the young person’s decision appears to lead to the wrong implications or consequences? The right to make health care decisions could be waived-if the responsibility was too much.”

There was a consensus among most of the group that when drafting the law the focus should be on young people - older teens:

“Like a child aged 9 or 10 is not capable of going to the doctor on their own, but might need access to a doctor for advice, like for example mental health issues - the parents in question could be the cause of the problem. But young children need guidance - they might be just attention seeking. Maybe a teacher could bring the child to the doctor?”

“Maturity and understanding are more relevant than age-it’s not right to use age to decide if a child or a young person can consent, no real difference between a young person who is 12 one day and 13 the next.”

There’s a reason why the law is vague - it’s too difficult to set in stone.”

1.75 At the end of the consultation day, the participants were asked to draw up some key points to aid the Commission in their work:

- It depends.....group couldn't decide if age or maturity was more important, depends on a specific case and a specific individual. Varying views regarding a cut-off age – consent should be based on age and or maturity.
- Doctors should be given guidelines regarding maturity and decision making. Informed consent is really important - and you should be able to voice your opinion, even if you can't consent.
- Best interests of the child or young person is important - a holistic best interests though, not just medical.
- Confidentiality should be respected - but related to the situation. Take cultural context into account - if a person is very shy for example, they might have limited communication with parents so confidentiality would be very important to them.
- Promote developments of other supports for young people, if there was more access to information certain issues wouldn't be taboo and confidentiality wouldn't be such a big issue.
- It's essential to inform young people, even those below the age of consent. Growing up is much easier if you are informed, there's a gradual assumption of responsibility. Too much responsibility at once is a lot of pressure - be careful about placing too much responsibility on young people.

1.76 The consultation was extremely helpful and provided the Commission with a direct insight into the practical issues that matter to children and young people in relation to health care. The issue of confidentiality was extremely important to the participants, as was the option of having someone to talk to for advice and support. The importance of treating children and young people as individuals was also raised by a number of participants. The cost of services was emphasised as a significant deterrent and barrier to the access of services.

1.77 In relation to the age of consent to medical treatment, the group found it difficult to reach a conclusion on the issue. Generally speaking, 16 was seen as an age where most young people would be competent to consent to medical treatment, however the participants made it clear that any age based rule would have to be flexible and take the maturity of particular individuals into account.

1.78 Other consultations carried out with children and young people, mainly in a hospital setting, found that children want to be involved in the consultation process.⁷² The process of consultation, of voicing their opinion and being involved was more important for many children than the act of decision making. In general, children wanted to make decisions in partnership with their parents and doctors.

“The findings indicate that the issue of decision-making should be seen as being a continuum rather than on an ‘all or nothing’ basis. It should also be viewed as a process that is dependent on the type of decision, child, parents and health professional’s opinions, and the situational context.”

1.79 The provision of information is very important to children and young people in hospital as it helps them to prepare for different tests and treatments and thus reduces worry and fear of the unknown. Studies have shown that when children are informed about their condition and treatment, they are more willing to co-operate and in general, show less upset and recover well.⁷³

1.80 Parents can both help and hinder children in relation to provision of information and the child’s level of participation in the decision-making process. Parents are often seen as a gateway to information, managing what and how their children are told about their illness and treatment. Some parents play a key role in ensuring that their children are informed and prepared, whilst others actively constrain the level of information available to a child. Children who actively seek information can also be discouraged by difficulty in understanding medical terminology, and a lack of time or willingness on the part of a medical professional to explain things to them.

1.81 As mentioned above, a simple all or nothing approach is not appropriate in the context of children’s consultation and participation in health

⁷² See generally Coyne et al *Giving Children a Voice: Investigation of children’s experiences of participation in consultation and decision-making in Irish hospitals* (Office of the minister for Children 2006), Kilkelly & Donnelly *The Child’s Right to be Heard in the Healthcare Setting* (Office of the Minister for Children 2006), Bates et al “I’ve Come for his Throat: roles and identities in doctor-parent-child communication” (2002) 28 *Child: Care, Health & Development* 28 at 109, Alderson, *Children’s Consent to Surgery* (Open University Press 1993), Alderson “Children’s Competence to Consent to Medical Treatment” (2006) 36(6) *Hastings Centre Report*.

⁷³ Coyne et al *Giving Children a Voice: Investigation of children’s experiences of participation in consultation and decision-making in Irish hospitals* (Office of the minister for Children 2006) at 55.

care decisions. Referring to Article 12 of the Convention on the Rights of the Child, giving children a voice in matters which affect them does not entail giving them the sole responsibility for all decisions. A research study carried out in 2006 for the Office of the Minister for Children concluded that:

“The findings indicate that decision-making for children is a complex process that evolves over time and that may be shared or contested with parents and health professionals depending on the type of decision. It suggests a pragmatic approach, which recognises that children need protection while at the same time allowing flexibility for the child’s emerging knowledge and self-determination.”⁷⁴

⁷⁴ *Ibid* at 57.

CHAPTER 2 DEVELOPMENT OF A MINORITY STATUS

2.01 This chapter contains an account of the law relating to minority status and highlights the importance of reviewing different ages of consent in line with societal developments and the evolving capacity of children and adolescents. Part B begins with an overview of the guiding principles which underpin the creation of different age limits and ages of consent. The historical background and development of the age of majority is outlined in Part C. The legal rights and responsibilities granted before majority status is attained are outlined in Part D.

A Guiding Principles on Age Limits

2.02 Age limits are set out for the protection of children, to shield them from engaging in damaging behaviour and to prevent them from a level of decision-making which may be beyond their understanding and maturity. An age limit or an age of consent represents a legal boundary between protection of the child and recognition of the capacity of the child to undertake certain actions or make certain decisions. This is not to infer that the child has reached the age of majority, or is considered an adult. Upon reaching a particular age limit or age of consent the child is still a child and is entitled to the rights and protection which flow from such status.

2.03 Modern societies do not condense the distinctions between a child and an adult into a single rite of passage. Instead, the boundary between adulthood and childhood is marked by numerous junctures which enable the child to develop, and gradually accumulate the maturity and skills to make decisions as an adult. The gradual development and maturing process of assuming adulthood is reflected by legal punctuations where rights are assumed and responsibilities granted.

2.04 The differing ages of responsibility and entitlement which apply to different activities are complex and may seem irrational. Thus:

- A ten year old is deemed capable of committing murder or rape, but must reach 12 before being deemed capable of committing theft.⁷⁵
- A 14 year old can, subject to significant restrictions, begin to earn a livelihood.⁷⁶
- A 16 year old may engage in full time employment and obtain a licence to drive a motorcycle but must reach 17 years of age in order to drive a car.⁷⁷
- A person must be 18 years of age in order to vote or be a member of a jury.⁷⁸
- A person must be 21 years of age in order to be elected to the Dail.⁷⁹

2.05 To a certain degree, the complexity can be viewed as a reflection of the fact that growing up in Ireland today is in itself a complex process, in which multiple dimensions of the transition from childhood to adulthood must be provided for.⁸⁰ The law reflects a progressive approach to the transition from child to adult, from incapacity to capacity, by incrementally granting legal rights and responsibilities to a child over the course of childhood and adolescence.

2.06 This can be viewed as part of the 'evolving and enabling' approach advocated by the Convention on the Rights of the Child 1989. Article 5 of the Convention reads:

“State Parties shall respect the responsibilities, rights and duties of parents....to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognised in the present Convention.”

2.07 Article 5 contains the principle that parents and others have the responsibility to continually adjust the levels of support and guidance they offer to a child, effectively enabling children to participate more in the realisation of

⁷⁵ Section 129 of the *Criminal Justice Act 2006*.

⁷⁶ Section 4 of the *Protection of Young Persons Employment Act 1996*.

⁷⁷ Section 6 of the *Protection of Young Persons Employment Act 1996*, Section 31 of the *Road Traffic Act 1961*.

⁷⁸ Section 6 of the *Juries Act 1976*, Section 4 of the *Age of Majority Act 1985*.

⁷⁹ Section 1 of the *Electoral Act 1923*.

⁸⁰ Lalor et al *Young People in Contemporary Ireland* (Gill and Macmillan 2007) at 268.

their rights. These adjustments take account of a child's interests and wishes as well as a child's capacity for autonomous decision making and comprehension of what is in his or her best interests. A General Comment issued by the Committee on the Rights of the Child in 2005 emphasised the process of maturation and learning whereby children progressively acquire knowledge, competencies and understanding, and highlighted the importance of the enabling approach, stating that respect for young children's evolving capacities is crucial for the realisation of their rights.⁸¹

“The more the child himself or herself knows, has experienced and understands, the more the parent, legal guardian or other persons legally responsible for the child have to transform direction and guidance into reminders and advice and later to an exchange on an equal footing. This transformation will not take place at a fixed point in a child's development, but will steadily increase as the child is encouraged to contribute her or his views.”⁸²

2.08 The Committee has stressed that the level of protection needed by the developing child at different stages changes over time, and parents and others have the responsibility to continually adjust the levels of support and guidance offered to a child. This point was echoed in the recommendation of the Joint Committee on Child Protection:

“the different ages of maturity and consent be reviewed, and kept under continuing review, in order to ensure consistency and coherence, and to ensure that sufficient recognition is given to the dawning maturity of children at appropriate ages”⁸³

2.09 In general terms, therefore, the Commission concludes that three guiding principles can be applied to the creation and maintenance of different age limits that define the boundary between childhood and adulthood for specific purposes. First, legal age limits must strive to achieve a balance between the need to protect children and the importance of enabling them to

⁸¹ The Committee on the Rights of the Child is the body of independent experts that monitors implementation of the Convention on the Rights of the Child by its State Parties.

See Committee on the Rights of the Child “Implementing Child Rights in Early Childhood” (General Comment No 7 of 2005 CRC/C/GC/7 Rev 1 2006) at 17.

⁸² Committee on the Rights of the Child “The Right of the Child to be Heard” (General Comment No.12 of 2009 CRC/C/GC/12) at 84.

⁸³ Joint Committee on Child Protection *Report on Child Protection* (Houses of the Oireachtas 2006) at 7.2.4.

exercise their own rights. Second, regular review ensures that age limits are in line with social realities and correlate with modern research regarding the cognitive and decision-making abilities of children. Third, review of age limits will also enhance consistency and reduce complexity and criticism of the various age limits in force.

B Development of Minority Status

2.10 Section 2 of the *Age of Majority Act 1985* currently defines a minor, for many, though not all legal purposes, as a person under the age of 18 years who is not or has not been married.⁸⁴ Minority is a status which was recognised by the common law and goes back to the earliest times.⁸⁵ Traditionally, limitations have been placed on the legal capacity of a minor to protect the minor against his or her inexperience and improvidence.⁸⁶

“Infants have various privileges, and various disabilities: but their very disabilities are privileges: in order to secure them from hurting themselves by their own improvident acts”⁸⁷

2.11 The age of majority marks the cessation of minority status. Under Irish law, the age of majority is reached when a person turns 18 years of age, or in case he marries before attaining that age, upon his marriage.⁸⁸ The occasion is noted in different ways and at different ages by various societies worldwide. The age at which the transition from minority to majority status takes place reflects the culture and laws of a particular society.

2.12 The change from minority to majority status can be viewed as a transition from childhood to adulthood, which is marked by the absorption of legal rights and responsibilities. When a child is recognised as an adult in the eyes of the law, he or she is deemed to have reached a level of maturity where protections such as age limits are no longer appropriate.

⁸⁴ The *Age of Majority Act 1985* largely implemented the recommendations made by the Commission in its *Report on the Law Relating to the Age of Majority, the Age for Marriage and Some Connected Subjects* (LRC 5 1983).

⁸⁵ Law Reform Commission *Working Paper on the Age of Majority the Age for Marriage and some Connected Subjects* (No. 2 1977) at 2.1.

⁸⁶ *Ibid* at 2.2.

⁸⁷ Blackstone “Of Guardian and Ward” 1723-1780 Book 1 Chapter 17 in *Commentaries on the Laws of England* (University of Chicago Press 2002) at 452.

⁸⁸ Section 2 of the *Age of Majority Act 1985*.

(i) Historical Background

2.13 Although the pre-Norman Brehon Laws recognised a form of legal protection for children, the concept of a fixed age at which a child would attain maturity was apparently not known to them. In general, a son had no power to make a binding contract during the life of his father and while he was a member of his father's household.⁸⁹ Following the Norman invasion of Ireland, English laws and systems of organisation were gradually imposed. Several hundred years passed before the English common law system, supplemented by statute law, effectively became law throughout Ireland.

2.14 The English Lately Committee Report on the Age of Majority traced the historical development of the common law age of majority back to the 9th century.⁹⁰ 15 years was the general age of majority in Britain and Northern Europe during the 9th, 10th and 11th centuries. The Norman Conquest led to a greater emphasis on military power and the mounted knight. By the time of the Magna Carta the age for those in knight service had been raised to 21 years, possibly related to the ability to hold a heavy suit of armour whilst wielding a weapon⁹¹. The threshold of 21 years as a boundary between child and adulthood was well established under the feudal system of the Middle Ages, where 21 was the age of majority for holding land under military tenure. The *Tenures Abolition Act 1660* ended the system of military tenure and 21 became the age of full capacity for socage tenure (tenure of land by services other than knight service).⁹²

2.15 As years passed the age of 21 became firmly established as the age of majority. Minors could however partake in certain events and make certain decisions before reaching 21 years.⁹³ A male aged 12 years of age could take an oath of allegiance and reached the age of legal discretion at 14 years upon which he could choose his guardian or marry. At 21 years he had reached full age and could aliene his lands, goods and chattels.⁹⁴ A female aged 7 years of age could be betrothed or given in marriage, was entitled to a dowry at 9 years

⁸⁹ Law Reform Commission *Working Paper on the Age of Majority the Age for Marriage and some Connected Subjects* (No. 2- 1977) at 2.4.

⁹⁰ *Report of the Committee on the Age of Majority 1967* (London Cmnd.3342).

⁹¹ The Magna Carta 1215.

⁹² Alberta Law Reform Institute *Age of Majority* (Report 4 1971) at 3.

⁹³ See generally Blackstone "Of Guardian and Ward" 1723-1780 Book 1 Chapter 17 in *Commentaries on the Laws of England* (University of Chicago Press 2002).

⁹⁴ *Aliene* –Alienation "to exercise the power of disposing of or transferring property" Murdoch *Murdoch's Dictionary of Irish Law* (3rd ed Topaz Publications 2000).

of age and was considered mature enough to consent to marry at 12 years of age. Like a male, she reached the age of legal discretion at 14 years and attained majority status at 21 years of age. It is clear that much of the historical background and development of the law regarding the age of majority and the threshold of 21 years was derived from ownership and legal rights over land.

2.16 Throughout the 1960's and 1970's the law relating to majority status was the subject of considerable assessment. A consensus developed in common law jurisdictions in favour of lowering the age of majority from 21 years to, in most cases, 18 years. The Report of the English Latey Committee proved influential, particularly its review of the history of the age of majority and the statement that:

“there is nothing particularly god-given about the age of twenty-one as such”.⁹⁵

(ii) Council of Europe Resolution on the Lowering of the Age of Full Legal Capacity

2.17 In 1970 the Council of Europe's Committee on Legal Co-operation established a committee to consider the question of full legal capacity. The Committee felt that new considerations of a biological, family and social character had demonstrated the need to review the age at which a person acquired full legal capacity.⁹⁶ Young people were maturing earlier than before due to improving conditions of hygiene and nutrition, and a longer term of compulsory schooling. They were acquainted with social, economic and political problems and playing an important role in society. Following this analysis, a 1972 Committee of Ministers Resolution recommended that Member States should lower the age of majority to below 21 years, and if deemed advisable, fix the age at 18 years.⁹⁷ The Resolution acknowledged the fact that young people were equipped with the necessary information and education to meet the exigencies of life. Lowering the age of majority would encourage a sense of responsibility in young people and achieve greater unity among member states. Regarding Member States who wished to retain an age of majority above 18 years, the Committee recommended that governments consider granting certain

⁹⁵ *Report of the Committee on the Age of Majority 1967* (London Cmnd.3342) at 23.

⁹⁶ *Draft Resolution on the lowering of the age of full legal capacity and explanatory report* (European Committee on Legal Co-operation Council of Europe 31 July 1972).

⁹⁷ Resolution 72(29) *The lowering of the age of full legal capacity* adopted by the Committee of Ministers on September 19 1972.

minors capacity to carry out everyday transactions and act independently in appropriate fields.

2.18 In 1983, the Commission published a *Report on the Law Relating to the Age of Majority, the Age for Marriage and some Connected Subjects* recommending that the age of majority be lowered to 18 years.⁹⁸ The 1983 Report largely followed the provisional recommendations made in the Commission's *Working Paper on the Age of Majority the Age for Marriage and some Connected Subjects*⁹⁹. Later that year, the Oireachtas Joint Committee on Legislation endorsed the Commission's recommendations stating:

“A reduction in the age of majority will go some way to erase obsolete laws which do not reflect the ever growing consciousness that our young people with their sense of initiative, enterprise and adaptability are our true wealth.”¹⁰⁰

(iii) Change in Irish Law on Age of Majority

2.19 Following the Commission's 1983 Report and its endorsement by the Oireachtas Joint Committee on Legislation, the *Age of Majority Act 1985* reduced the age of majority from 21 to 18 years.¹⁰¹ It is notable that a child is defined as a person under 18 years of age for the purposes of the *Child Care Act 1991*, the *Children Act 2001* and the *Guardianship of Infants Act 1964*. 18 years is the age used in respect of matters of custody, access, maintenance, social welfare and taxation. The Convention on the Rights of the Child 1989 defines a child as “every human being below the age of 18 years unless under the law applicable to the child majority is achieved earlier.”

2.20 A person's 18th birthday clearly marks an important watershed and signals the end of the special protections granted under minor status. As outlined above, however, the transition from a child to an adult is not an instant

⁹⁸ Law Reform Commission *Report on the Law Relating to the age of Majority, the Age for Marriage and some connected subjects* (LRC 5-1983).

⁹⁹ Law Reform Commission *Working Paper on the Age of Majority the Age for Marriage and some Connected Subjects* (No. 2 1977).

¹⁰⁰ Joint Committee on Legislation *Report on Age of Majority* (Houses of the Oireachtas 1983) at 7.3.

¹⁰¹ Section 21 of the *Interpretation Act 2005* defines ‘full age’ as “the time when the person attains the age of 18 years or sooner marries, or any time after either event”.

occurrence and the distinction between an adolescent and an adult is not demarcated by a single rite of passage.

(iv) Different Ages of Capacity in Irish Law

2.21 The Commission's 1977 Working Paper on *the Law Relating to the Age of Majority, the Age for Marriage and some Connected Subjects* contains a study of the various relationships between age and the law, from 5 years of age up to 35 years of age.¹⁰² There are a broad range of legal provisions which are directed at children and the gradual assumption of adult rights and responsibilities. These provisions cover a range of activities such as employment, education, vehicle driving licences, criminal responsibility and consumption of alcohol and tobacco. It is interesting to study how the different ages connected to different activities and legislative provisions have changed over the years, in response to changing circumstances and attitudes. For example, under the *Children Act 1908* it was an offence to give intoxicating liquor to a child under 5 years of age.¹⁰³ The *Mines and Quarries Act 1965* stated that a child under the leaving school age of 15 years could not be employed at a mine. A male, upon reaching the age of 18 could qualify for unemployment assistance in accordance with the provisions of the *Unemployment Assistance Act 1933*¹⁰⁴.

C Rights and Responsibilities of Minors

2.22 Current employment legislation states that a child over the age of 13 years can undertake certain types of employment of a cultural, artistic sporting and advertising nature.¹⁰⁵ Such employment is authorised by Ministerial Regulations and cannot interfere with school attendance or the safety and development of the child. In relation to other types of employment, the *Protection of Young Persons Employment Act 1996* sets 14 as the minimum age for employment and is based on a graduated scheme which allow older children to work an increasing number of hours provided that the work does not interfere with their health, development or education.¹⁰⁶

¹⁰² Law Reform Commission *The Law Relating to the Age of Majority, the Age for Marriage and some Connected Subjects* (LRC 2 1977) at appendix B.

¹⁰³ Under more recent legislation on intoxicating liquor, it is an offence to purchase or serve alcohol to anyone under the age of 18, unless in a private residence.

¹⁰⁴ Section 10(3) of the *Unemployment Assistance Act 1933*.

¹⁰⁵ Section 3(3) of the *Protection of Young Persons Employment Act 1996*.

¹⁰⁶ Section 3 of the *Protection of Young Persons Employment Act 1996*.

2.23 A person's 16th birthday is a significant point in the progression from minor to majority status. Traditionally, a 16 year old reached a significant measure of independence upon his or her 16th birthday. The *Children Act 1908* defined a child as a person under the age of 15 years of age and a young person as a person between the ages of 14 and 16¹⁰⁷. Under the *Social Welfare (Supplementary Welfare Allowances) Act 1975a* man had to maintain his children until they reached the age of 16.¹⁰⁸ Under the *Marriages Act 1972* a 16 year old could marry. Under the *Health Acts 1947 to 1970*, a person aged 16 and over was treated as an adult. These provisions have been amended in line with changes to modern society however the traditional threshold of 16 as an indication of independence has been retained. For example, a 16 year old has finished compulsory education and can engage in full time employment. Under road traffic legislation, a 16 year old can drive certain types of vehicles such as motorcycles, tractors and mopeds and a 17 year old can drive most vehicles.¹⁰⁹

2.24 The *Protection of Young Persons Employment Act 1996* defines a child as a person under 16 and defines a young person as a 16 or 17 year old.¹¹⁰ For the purposes of compulsory education, under the *Education (Welfare) Act 2000*, a child is defined as a person between 6 and 16 years old. This is in line with the 1994 Directive on the Protection of Young People at Work which defines a child as any young person less than 15 years of age or subject to compulsory full time schooling.¹¹¹ In a similar vein, the *Child Abduction and Enforcement of Custody Orders Act 1991* which gave domestic effect to the Hague Convention on the Civil Aspects of International Child Abduction ceases to apply when a child reaches the age of 16.¹¹²

¹⁰⁷ Section 130 of the *Children Act 1908*.

¹⁰⁸ Section 3 of the *Social Welfare Consolidation Act 2005*, a qualified child is defined as a person who is under the age of 18 years, or over the age of 18 years and attending a course of study.

¹⁰⁹ Section 31 of the *Road Traffic Act 1961*.

¹¹⁰ Section 1 of the *Protection of Young Persons Employment Act 1996* "child" means a person who is under 16 years of age or the school- leaving age, whichever is higher. "young person" means a person who has reached 16 years of age or the school leaving age (whichever is higher) but is less than 18 years of age.

¹¹¹ Council Directive 94/33/EC of 22 June 1994 on the protection of young people at work. The Directive defines an adolescent as "any young person of at least 15 years of age but less than 18 years of age who is no longer subject to compulsory full-time schooling under national law".

¹¹² Article 4 of the Hague Convention on the Civil Aspects of Child Abduction.

2.25 A motion for a resolution was presented to the Parliamentary Assembly of the Council of Europe to lower the voting age to 16.¹¹³ The motion called for an investigation on the advantages and drawbacks of engaging and securing young people's participation in the democratic process by lowering of the voting age to 16 in all member countries of the council of Europe.

2.26 In the context of health care, the age of 16 has been accepted as an important watershed in various jurisdictions and has been largely accepted as the age of consent to medical treatment. Section 23 of the *Non-Fatal Offences Act 1997* discussed in chapter 4 states that a 16 year old may consent to medical treatment¹¹⁴, and as mentioned above the *Health Acts 1947 to 1970*, treated persons aged 16 and over as adults. Article 4(1) of the *European Communities (Clinical Trials on Medicinal Products for Human Use) (Amendment) Regulations 2004* state that an adult is a person who has attained the age of 16 years¹¹⁵.

2.27 Aside from reaching the age of 16 and 18, another important watershed for children in Irish law is the age at which they can be held responsible for criminal actions. There is a discernable difference in approach between criminal and civil responsibility, with the law imposing criminal responsibility on a child from a young age whilst simultaneously withholding civil responsibility. Commentary on the 1985 UN Standard Minimum Rules for the Administration of Juvenile Justice (the Beijing Rules) suggests there should be a close relationship between the age of criminal responsibility and the age where civil and social responsibilities are granted.¹¹⁶ A General Comment adopted by the Committee on the Rights of the Child identifies 12 as the minimum age of criminal responsibility and promotes a higher age.¹¹⁷

2.28 Under common law the age of criminal responsibility in Ireland was set at 7 years of age, based on a conclusive presumption that children under seven were *doli incapax* (incapable of crime) because they could not form the requisite *mens rea*. Children aged between 7 and 14 years of age were covered

¹¹³ Parliamentary Assembly "Expansion of democracy by lowering the voting age to 16" (Doc. 11895 4 May 2009) available at <http://assembly.coe.int/>

¹¹⁴ See 4.02.

¹¹⁵ SI No 190 of 2004. The 2004 Regulations implemented the 2001 EC Directive on Clinical Trials on Medicinal Products for Human Use, Directive 2001/83/EC.

¹¹⁶ UN Standard Minimum Rules for the Administration of Juvenile Justice 1985 (Beijing Rules) adopted by General Assembly resolution 40/33 of 29 November 1985 at 4.1.

¹¹⁷ General Comment *Children's Rights in Juvenile Justice* CRC/C/GC/10 (2007).

by a rebuttable presumption, which could be rebutted by showing that the child in question knew the difference between right and wrong. The age of criminal responsibility has undergone substantial change in recent years.¹¹⁸ Section 52 of the *Children Act 2001* introduced provisions to raise the age of criminal responsibility to 12 years. However, section 52 of the 2001 Act was not commenced and it was ultimately amended by section 129 of the *Criminal Justice Act 2006* which introduced a dual approach to the age of criminal responsibility. As amended, the 2001 Act contains a general rule that children under 12 years of age cannot be charged with an offence. An exception however exists in relation to murder and rape offences, in respect of which criminal responsibility now applies from 10 years of age. In England, the age of criminal responsibility for all offences is set at 10 years of age under the *Children and Young Persons Act 1933*, as amended.¹¹⁹ This has been criticised, as most European countries have adopted higher ages of criminal responsibility.¹²⁰

Reviewing Ages of Consent

2.29 This chapter provided an overview of the law relating to minority status and places the present law within its historical context. As the 1983 *Report of the Oireachtas Joint Committee Report on Age of Majority* stated:

“A sense of the past may help us to understand the present but it should not determine our capacity to respond to new needs or to meet new challenges”¹²¹

Society is continually evolving and the law must respond to such change by keeping the ages of consent under review and adapting to new developments

¹¹⁸ See Kilkelly “Reform of Youth Justice in Ireland: The “New” Children Act 2001 Part 1” (2006) *Irish Criminal Law Journal* 16(4) “Reform of Youth Justice in Ireland: The “New” Children Act 2001 Part 2” (2007) *Irish Criminal Law Journal* 17(1).

¹¹⁹ *The Children And Young Persons Act 1933* was amended by Section 16 of the *Children and Young Persons Act 1963*, raising the age of criminal responsibility from 8 to 10 years of age.

¹²⁰ Fortin *Children’s Rights and the Developing Law* (2nd ed Butterworths 2003) at 550, *Concluding Observations of the Committee on the Rights of the Child* Committee on the Rights of the Child CRC/C/15/Add 18 (2002) at para 59. For similar criticisms of the 2001 Act, as amended by the 2006 Act, see Kilkelly *Children’s Rights in Ireland* (Tottel Publishing 2008) at 537.

¹²¹ *Report on Age of Majority* Joint Committee on Legislation (Houses of the Oireachtas 1983) at 7.3.

and conditions. This point was echoed in 2006 by the Oireachtas Joint Committee on Child Protection, in its call to keep ages of consent under review and to acknowledge the capabilities of children by granting them legal capacity over different elements of their lives.¹²²

¹²² *Report on Child Protection*, (Joint Committee on Child Protection) (Houses of the Oireachtas 2006) at para 7.2.4.

CHAPTER 3 A DEFINITION OF MEDICAL TREATMENT TO MEET THE MEDICAL CONCERNS OF CHILDREN AND ADOLESCENTS

A Introduction

3.01 This chapter begins with a discussion of the extent to which it is possible to define the term “medical treatment” and associated wider terms such as “health care.” At present, there is no single all-purpose definition of these terms. This reflects their potentially wide-ranging scope of application and the ongoing use and development of new technologies and procedures in health care and medical practice. In Part B, the Commission discusses the different uses of the term “medical treatment” in Irish law and developments that have occurred in this respect in other countries. Part C explores the medical concerns of Irish children and young people in order to consider the types of treatments which are most important to them and their continuing development. In Part D, the Commission discusses how the issue of consent to medical treatment has arisen in many countries in the specific context of the provision of contraceptive advice and treatment to improve sexual health. The Commission discusses this with a view to setting out a number of general proposals on consent to treatment in Part E.

B Defining Health Care and Medical Treatment

(1) Ireland

3.02 At present, there is no explicit statutory definition of what constitutes medical treatment or wider terms such as health care. The various *Health Acts* refer to medical services, dental services, in-patient and out-patient services but do not offer definitions as to the precise meaning of medical treatment or health care.¹ The absence of a single description of such terms is understandable

¹ Section 51 of the *Health Act 1970* defines ‘in-patient service’ as “institutional services provided for persons while maintained in a hospital, convalescent home or home for persons suffering from physical or mental disability or in accommodation ancillary thereto.” Section 2 of the *Medical Practitioners Act 1978* defined the ‘practice of medicine’ as including the “practice of surgery, midwifery and other disciplines of medicine and ‘medical practitioner’ shall be construed

because health care and medical treatment move at a rapid pace, encompassing new and improving technologies and procedures. Health care and medical practice, supported by new technology offers patients more hope of successful treatment and recovery than ever before.²

3.03 The *Health Insurance Act 1994* contains a definition of “health services” for the specific purpose of the regulation of health insurance:

health services means “medical, surgical, diagnostic, nursing, dental, chiropody, chiropractic, eye therapy, occupational therapy, physiotherapy, or speech therapy services or treatment or services or treatment provided in connection therewith, or similar services or treatment.”³

3.04 Section 23(2) of the *Non-Fatal Offences Against the Person Act 1997*, which provides a defence to a charge of assault where a person aged 16 consents to medical treatment, states:

“In this section ‘surgical medical or dental treatment’ includes any procedure undertaken for the purposes of diagnosis, and this section applies to any procedure (including, in particular the administration of an anaesthetic) which is ancillary to any treatment as it applies to that treatment.”

3.05 The Law Society of Ireland’s Law Reform Committee suggested that the definition in section 23 includes exploratory acts for the purposes of diagnosis, as well as treatment. Furthermore, the inclusion of anaesthesia under the term ‘procedure’ suggests that procedure is intended to cover more than examination and non-invasive actions.⁴

3.06 The *Child Care Act 1991* seems to envisage a distinction between examination and treatment. Section 13(7) of the 1991 Act states that the court may give directions with respect to “the medical or psychiatric examination, treatment or assessment of the child”. The Law Society’s Law Reform Committee has recommended that the distinction between examination and

accordingly.” Section 2 of the *Medical Practitioners Act 2007* which replaced the 1978 Act defines a medical practitioner as “a person who holds a basic medical qualification” and the practice of medicine includes “the practice of surgery and other disciplines of medicine”.

² Madden *Medicine, Ethics and the Law* (Butterworths 2002) at 22.

³ Section 2 of the *Health Insurance Act 1994*.

⁴ Law Society’s Law Reform Committee *Rights-based Child Law: The Case for Reform* (Law Society of Ireland 2006) at 186.

treatment should be clarified in legislation, with examination defined as non-invasive, and invasive exploratory acts for the purpose of diagnosis included in the definition of treatment.⁵

3.07 Various law reform agencies in other countries have grappled with the question of how to define medical treatment. Generally speaking, most of the literature available from these bodies focuses on creating a broad definition of medical treatment ensuring that children have access to the types of medical care and treatment that they need.

(2) England

3.08 Section 8 of the English *Family Law Reform Act 1969*, which can be viewed as the statutory analogue for section 23 of the *Non-Fatal Offences Against the Person Act 1997* states that “surgical, medical or dental treatment” includes any procedure undertaken for the purposes of diagnosis, and applies to any procedure (including, in particular, the administration of anaesthetic) which is ancillary to any treatment as it applies to that treatment.

3.09 The English *Children Act 1989* refers to medical and psychiatric examination and treatment but does not define these terms. The various pieces of legislation dealing with health care, medical practitioners, health insurance and so on contain different definitions in line with the different purposes of each Act⁶. For example, the *Health And Social Care Act 2008* defines health care as “all forms of health care provided for individuals, whether relating to physical or mental health and also includes procedures that are similar to forms of medical or surgical care but are not provided in connection with a medical condition.”⁷

(3) Australia

3.10 The definition of medical treatment in the context of minor’s ability to consent to medical treatment has been addressed by the Law Reform Commission of Western Australia, the Queensland Law Reform Commission and more recently, in 2008 the New South Wales Law Reform Commission.

⁵ Law Society’s Law Reform Committee *Rights-based Child Law: The Case for Reform* (Law Society of Ireland 2006) at 186.

⁶ Section 128 of the *National Health Service Act 1977* defines illness as including “mental disorder within the Mental Health Act 1983 and any injury or disability requiring medical or dental treatment or nursing”. Section 18 (4) of the *Health Act 1999* defines health care as “services for or in connection with the prevention, diagnosis or treatment of illness”.

⁷ Section 9(2) of the *Health and Social Care Act 2008*.

(i) Western Australia

3.11 In its 1988 discussion paper on *Medical Treatment for Minors*, the Western Australia Law Reform Commission defined medical treatment broadly, including services performed by health care professionals who are not doctors in the traditional sense, but carry out health procedures which are now viewed as routine and essential.⁸

(ii) South Australia

3.12 *The Consent to Medical Treatment and Palliative Care Act 1995* provides a statutory framework to deal with issues of consent by adults and young people. Medical treatment is defined as “treatment or procedures administrated or carried out in the course of medical or surgical practice or by a dentist in the course of dental practice and includes the prescription or supply of drugs.”⁹

(iii) Queensland

3.13 In 1996 the Queensland Law Reform Commission published a report on minor’s consent to medical treatment, including a proposed legislative scheme. The proposed scheme divided children into groups based on age, enabling children to progressively make more and more decisions regarding their health and medical treatment.¹⁰

3.14 In the 1995 discussion paper that preceded the Report, the Queensland Commission discussed the issue of how to define medical treatment and requested comments on a suitable definition of ‘treatment’ and ‘health care provider’.¹¹ The discussion paper relied on broad definitions of the terms of medical procedure, treatment and health care provider. Upon consideration of the submissions received, the Queensland Commission decided that the term ‘treatment’ was too narrow, as the term is usually associated with procedures carried out by medical practitioners and dentists. The broader term ‘health care’ was favoured to cover the care provided to young people by the range of different practitioners recognised as in the

⁸ Law Reform Commission of Western Australia *Medical Treatment for Minors* (Discussion Paper Project No. 77 1 1988) at 4.

⁹ Section 4 of the *Consent to Treatment and Palliative Care Act 1995*.

¹⁰ Queensland Law Reform Commission *Consent to Health Care of Young People: Volume Three* (Report 51 1996) at 12.

¹¹ Queensland Law Reform Commission *Consent to Medical Treatment of Young People* (Discussion Paper 44 1995) at 8.

business of improving the health of others. The Report set out the following definition:

“Health care of a young person is any assessment, care, treatment, service or procedure to maintain, diagnose or treat the young person’s physical or mental condition”.¹²

3.15 Regarding the term ‘health care provider’ the Queensland Commission was anxious to ensure that a broad range of health care providers would be covered under the proposed legislative scheme.

“The doctor-patient relationship is not the only professional relationship concerned with addressing significant health related problems or concerns. Health care by nurses, dentists, counsellors, psychologists and numerous other health care providers also play an important role in ensuring the physical and psychological health and well-being of people”¹³

3.16 Furthermore, there are serious consequences of unsuitable or inappropriate care, regardless of whether the care is provided by a traditional or non-traditional health care provider. A broad definition of health care provider was adopted:

“For the purposes of this Report a ‘healthcare provider’ will be defined as a person who provides healthcare in the practice of a profession or in the ordinary course of business.”¹⁴

(iv) New South Wales

3.17 In 2004 the New South Wales Law Reform Commission published an issues paper on *Minors Consent to Medical Treatment*, which outlined the difficulty of creating a concrete definition of medical treatment; namely the difficulty of reaching a definition which does not exclude the broad range of alternative health services which are not traditionally recognised as medical services, but are beneficial to a person’s health and well-being.¹⁵ Initially, the New South Wales Commission adopted a narrow interpretation of medical treatment as a starting point for further debate and public consultation.

¹² Queensland Law Reform Commission *Consent to Health Care of Young People: Volume One* (Report 51 1996) at 18.

¹³ Queensland Law Reform Commission *Consent to Health Care of Young People: Volume One* (Report 51 1996) at 20.

¹⁴ *Ibid* at 21.

¹⁵ New South Wales Law Reform Commission *Minors Consent to Medical Treatment* (Issues Paper 24 2004) at 20.

3.18 In the subsequent 2008 report *Young People and Consent to Health Care* the New South Wales Commission significantly broadened the definitions used, basing the proposed legislative scheme on the key terms of health practitioner, health service and health registration.¹⁶ Essentially, the Commission's definition of medical treatment covers almost every service provided by a registered health professional.

3.19 A health service is defined as a service provided by a health practitioner, as a public or private service. An inclusive list follows, covering medical, dental, mental health, pharmaceutical and community health services. Alternative health care services are also included, as are any other services prescribed by regulation as a health service for the purposes of the legislation. Including a list in the definition was viewed as the most favourable option because it covers specific services but is not overly restrictive, as there are no definite limitations or exclusions. Predictive genetic testing and palliative care are included as a medical health service however the New South Wales Commission explicitly stated that the ordinary meanings of 'medical treatment' and 'palliative care' are not broad enough to include the withdrawal of life-sustaining treatment. Furthermore, end-of-life decisions were outside the New South Wales Commission's terms of reference.

3.20 The definition of a health practitioner is confined to practitioners registered under a health registration act. Unregistered practitioners are largely unregulated and do not undergo standardised training. Under the proposed scheme, practitioners are given significant responsibility to assess the competence and capacity of a minor, and the New South Wales Commission felt it would not be appropriate to bestow such responsibility upon unregistered practitioners.¹⁷

(4) Canada

3.21 Several of the law reform agencies in Canada have also examined the issue of minor's consent to medical treatment. In 1975 the issue of the age of consent to medical, surgical and dental treatment was discussed at the Conference of Commissioners on Uniformity of Legislation in Canada. An Act entitled *Medical Consent of Minors* was adopted, which defined medical treatment as:

(a) "Surgical and dental treatment,

¹⁶ These terms were defined by adopting definitions from the existing *Health Care Complaints Act 1993*.

¹⁷ New South Wales Law Reform Commission *Young People and Consent to Health Care* (Report 119 2008) at 71.

- (b) Any procedure undertaken for the purpose of diagnosis
- (c) Any procedure undertaken for the purpose for preventing any disease or ailment
- (d) Any procedure undertaken for the purpose of preventing pregnancy
- (e) And any procedure that is ancillary to any treatment as it applies to that treatment.”

3.22 A number of provinces and territories throughout the country have defined terms such as ‘health care’ and ‘treatment’ in various pieces of legislation, primarily dealing with substitute consent to medical treatment. The definitions in general tend to be broad, covering diagnostic and cosmetic procedures. For example:

(i) Alberta

3.23 The Alberta Law Reform Institute published a background paper *Consent of Minors to Medical Treatment* and a report *Consent of Minors to Healthcare* in 1975.¹⁸ The Commission decided to use the term health care, defined as “treatment by a qualified medical or dental practitioner in the course of his practise, and includes mental and surgical care, prevention and diagnosis of disease or ailment, the administration of anaesthetics, procedures for the purpose of preventing pregnancy, and treatment given by any person pursuant to directions given in the course of practice by a qualified medical or dental practitioner, but does not include surgical sterilization.”¹⁹

(ii) Prince Edward Island

3.24 The *Consent to Treatment and Health Care Directives Act 1988* defines treatment as “a procedure or set of procedures that is done for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health related purpose, and includes a course of treatment or group of associated treatments²⁰”

¹⁸ Institute of Law Research and Reform Alberta *Consent of Minors to Medical Treatment* (Background Paper No. 9 1975) *Consent of Minors to Healthcare* (Report 19 1975/6).

¹⁹ Institute of Law Research and Reform Alberta *Consent of Minors to Medical Treatment* (Background Paper No. 9 1975) at 34.

²⁰ Section 1(p) of the *Consent to Treatment and Health Care Directives Act 1988* also contains a list of procedures which are not considered as treatment such as assessments or examinations.

(iii) Manitoba

3.25 *The Health Care Directives Act 1992* defines treatment as “anything that is done for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health related purpose and includes a course of treatment.”²¹

(iv) British Columbia

3.26 Section 17 of the *Infants Act 1996* provides for the consent of an infant to medical treatment and defines healthcare as “anything that is done for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health related purpose, and includes a course of healthcare”.

3.27 *The Health Care (Consent) and Care Facility (Admission) Act 1996* creates a distinction between major and minor health care. Health care is defined as “anything that is done for a therapeutic, preventative, palliative, diagnostic, cosmetic or other purpose related to health.”

Major health care means “(a) major surgery (b) any treatment involving a general anaesthetic (c) major diagnostic or investigative procedures (d) any health care designated by regulation as major health care.

Minor health care means “any health care that is not major health care, and includes (a) routine tests to determine if health care is necessary, and (b) routine dental treatments that prevents or treats a condition or injury caused by disease or trauma, for example

- (i) cavity fillings and extractions done with or without local anaesthetic and
- (ii) oral hygiene inspections.”

(v) Ontario

3.28 *The Health Care Consent Act 1996* defines treatment as “anything done for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health related purpose, and includes a course of treatment, plan of treatment or community treatment plan²²” The definition excludes the assessment or examination of a person to determine the general nature of the person’s condition, and other non-invasive acts such as taking a person’s health history.

(vi) Yukon

The Decision Making, Support and Protection to Adults Act 2003 defines health care as “anything done for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of healthcare

²¹ Section 1 of the *Health Care Directives Act 1992*.

²² Section 2(1) of the *Health Care Consent Act 1996*.

but does not include anything designated by the regulations as not constituting healthcare.”²³

(5) Conclusions

3.29 For the purposes of this Consultation Paper, the aim of the Commission is to establish an inclusive and workable definition of medical treatment, in the context of access to health care by children and young people. The definition contained in section 23 of the *Non-Fatal Offences Against the Person Act 1997* could act as a guide for a future definition, as could the definition of health services used in the *Health Insurance Act 1994*. The broader definitions from other countries could also serve as guides. In this respect, the Commission provisionally recommends that, in the context of determining the scope of consent to medical care and treatment, a broad definition of health care and treatment should be used that encompasses diagnosis and treatment, and invites submissions on the precise form of this definition.

3.30 *The Commission provisionally recommends that, in the context of determining the scope of consent to medical care and treatment, a broad definition of health care and medical treatment should be used to encompass diagnosis and treatment and invites submissions on the precise form of this definition.*

C Health Care and Medical Concerns of Irish Children

3.31 In order to reach a relevant and practical definition of medical treatment, it is useful to observe the medical concerns of Irish children in order to assess the types of treatment which are most important to them and their continuing development.

3.32 Adult health problems, mental and physical, can stem from childhood experiences. A high standard of children’s health care is of the utmost importance and prioritising the health of children is an investment in the future. Article 24(1) of the 1989 UN Convention of the Rights of the Child provides:

“State Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.”²⁴

(1) General Health

3.33 The health and well being of children is a priority in Ireland. 40% of all submissions received as part of the public consultation preceding the creation

²³ Section 1 of the *Decision Making, Support and Protection to Adults Act 2003*.

²⁴ Article 24(1) of the Convention on the Rights of the Child 1989.

of the State's National Children's Strategy focused on children's health and well being.²⁵ The submissions reflected an equal focus on mental and physical health, and an awareness of how the child is being treated, and should be treated, in the health care setting.

3.34 There are a range of reports and policy documents available on children's health covering alcohol and drug use, obesity, exercise, smoking, sexual health and mental health. Generally speaking, Irish children and young people are healthy and reports on children's health have shown considerable improvement in recent decades. The most recent report from the Health Behaviour in School Aged Children project (HSBC) published in 2009, studied the health and wellbeing of 11, 13, and 15 year olds in Ireland, England, Scotland and Wales. The percentage of young people who reported having good or excellent health was highest in Ireland, at a total of 88.4%, with older age groups reporting slightly lower levels of perceived health and life satisfaction.²⁶

3.35 However certain indicators show the health of Irish children as lagging behind other jurisdictions, and improvements have not been as sustained as one would have hoped. Conditions such as cystic fibrosis, spina bifida and downs syndrome are high amongst Irish children.²⁷ Cancer in childhood is rare by contrast with its prevalence in adulthood, yet it is one of the most frequent causes of non-traumatic deaths in children in Ireland. Overall incidence of childhood cancer is comparable to European findings albeit slightly higher, however survival rates are also above the EU average²⁸. A 2008 report on the *State of the Nations Children* looked at chronic health conditions and hospitalisation and found that the total number of hospital discharges amongst

²⁵ *Report of the Public Consultation: National Children's Strategy* (Stationary Office 2000) at 88-92.

²⁶ Looking at figures for all three countries, positive life satisfaction was lowest amongst the 15 year olds at 81.9%, followed by 13 year olds at 84.4% and 11 year olds at 87.7%. Brooks et al *Young People's Health in Great Britain and Ireland :Findings from the Health Behaviour in School Aged Children Survey 2006* (HSBC 2009) at 12.

²⁷ Annual Report of the Chief Medical Officer *Health of our Children* (Department of Health and Children 2000) at 58. See <http://www.cfireland.ie/> and <http://www.sbhi.ie/spina-bifida-hydrocephalus.htm>

²⁸ Stack et al "Childhood Cancer in Ireland: a population based study" (2007) 92 *Archives of Disease in Childhood* 890, at 890. Donnelly et al *Cancer in Ireland 1994-2004: A Comprehensive Report* (Northern Ireland Cancer Registry/National Cancer Registry Ireland 2009) at 37.

children aged 1-17 years increased by 8,733 between 2003 and 2007, with a total of 144,703 hospital discharges in 2007.²⁹

3.36 The National Disability Survey 2006 estimated that 11% of people with a disability are in the 0-17 age group, a relatively high statistic when one considers that this age group accounts for one quarter of the total population.³⁰ 75% of children with a disability have an intellectual and learning difficulty. In general, most people with learning, intellectual or speech difficulties acquired the disability in childhood. 13% of people with a mobility or dexterity disability had also acquired the disability from birth. The 2008 *State of the Nations Children* Report found that in 2007, the number of children registered as having an intellectual disability was 7,802.³¹ The number of children registered as having a physical and/or sensory disability was 8,373.³²

(2) Mental Health³³

3.37 The World Health Organisation has highlighted mental health as a vitally important public health issue which affects hundreds of millions of people worldwide.³⁴

“Mental health is a most important, maybe the most important, public health issue, which even the poorest society must afford to promote, to protect and to invest in.”³⁵

3.38 The World Health Organisation has estimated that one in four families has at least one member with a mental disorder at any point in time³⁶.

²⁹ *State of the Nation's Children* (Office of the Minister for Children and Youth Affairs 2008) at 104.

³⁰ Preliminary results available at:

http://www.cso.ie/newsevents/pressrelease_nationaldisabilitysurvey06first.htm

³¹ *State of the Nation's Children* (Office of the Minister for Children and Youth Affairs 2008) at 110.

³² *State of the Nation's Children* (Office of the Minister for Children and Youth Affairs 2008) at 110-117.

³³ Mental health and the provisions of the *Mental Health Act 2001* are discussed in detail in Chapter 6.

³⁴ World Health Organisation *Fact Sheet Euro03/03* (8 September 2003) at 4
<http://www.euro.who.int/document/mediacentre/fs0303e.pdf>

³⁵ *Ibid.*

³⁶ World Health Organisation *Fact Sheet Euro03/03* (8 September 2003) at 1
<http://www.euro.who.int/document/mediacentre/fs0303e.pdf>

Mental health problems are increasing, with one in five people in Europe expected to develop a depression during their lifetime.

3.39 The extent of mental health problems amongst Irish children and young people is a growing concern. There is no single method of assessing mental illness amongst children but different surveys and research studies suggest that mental illness is increasing amongst children and young people in Ireland. Studies have shown that 18% of the child population under the age of 16 will experience significant mental health problems at some stage, whilst a much smaller proportion, approximately 3-4% will suffer from a psychiatric disorder such as anorexia or an obsessive compulsive disorder³⁷.

3.40 A study carried out in 2006 in the south east of Ireland revealed significant numbers of children and young people dealing with mental health problems.³⁸ Young children under 5 years of age were found to be suffering from anxiety, social phobias and obsessive compulsive disorders, with 14.98% of this group qualifying as having one psychological disorder³⁹. The study estimated that 18.53% of 6-11 year olds and 21.11% of 12-18 year olds met the criteria for at least one psychological disorder⁴⁰. A number of children had suicidal thoughts and had formulated a suicide plan⁴¹ and a significant number had attempted suicide, 5% in the past year. There appears to be a consensus that the overall prevalence rate for child and adolescent mental health problems has been rising in nearly all developed countries⁴².

3.41 Over one-third of submissions received during the consultation for the National Children's Strategy dealt with mental health concerns, in particular the need for improved provision of psychiatric and counselling services for children and adolescents.⁴³ Dáil na nÓg chose to focus on the issue of mental

³⁷ *Annual Report of the Chief Medical Officer: Health of our Children* (Department of Health and Children 2000) at 88.

³⁸ Martin et al *The Clonmel Project: Mental Health Service Needs of Children and Adolescents in the South East of Ireland* (Health Service Executive 2006).

³⁹ *Ibid* at 3.

⁴⁰ Martin et al *The Clonmel Project: Mental Health Service Needs of Children and Adolescents in the South East of Ireland* (Health Service Executive 2006) at 3.

⁴¹ *Ibid* at 33, 40, 41.

⁴² See Hale & Fortin "Legal Issues in the Care and Treatment of Children with Mental Health Problems" in Rutter (ed) *Rutter's Child and Adolescent Psychiatry* (5th ed Blackwell 2008) at 106.

⁴³ *Report of the Public Consultation: National Children's Strategy* (Stationary Office 2000) at 90.

health as one of two key themes in 2008, and held debates on issues such as bullying, suicide, and drug and alcohol abuse.⁴⁴ The Ombudsman for Children has also expressed concern over the prevalence of mental health problems amongst children.

3.42 The 2008 report on the *State of the Nations Children* provides a snapshot of Irish children's health and standard of living. Irish children and young people are prone to early use and abuse of tobacco, alcohol and drugs. Alcohol abuse by children and adults remains a serious issue of concern in Ireland. A range of different studies and surveys have pointed to the high levels of alcohol consumed by Irish children and young people, particularly in comparison to their European counterparts. The *State of the Nations Children* report for example, revealed that 20.4% of children aged between 10 and 17 years of age reported being drunk in the last 30 days, a figure which placed Ireland 2nd highest in a table of other countries in terms of children's alcohol consumption.⁴⁵ The 2009 report of the European School Survey Project on Alcohol and other Drugs (ESPAD) found that 78% of Irish students had drunk alcohol in the past 12 months, which was similar to the average ESPAD student. Irish students however were intoxicated more often, with 47% stating that they had been intoxicated in the past 12 months.⁴⁶

3.43 As regards smoking, it is clear that the majority of smokers begin smoking in their youth. A survey of adult smokers revealed that 53% had started smoking before the age of 15⁴⁷. There has been a considerable fall in the

⁴⁴ In 2009, Dáil na nÓg voted on suggestions to improve mental health, namely a school taught course for senior students focusing on positive mental health awareness, and an online support service. See Dáil na nÓg *Delegate Report 2009* (Stationary Office 2009).

⁴⁵ *State of the Nation's Children* (Office of the Minister for Children and Youth Affairs 2008) at 136.

⁴⁶ Hibell et al *The 2007 ESPAD Report: Substance Use among Students in 35 Countries* (ESPAD 2009) at 108. See also Brooks et al *Young People's Health in Great Britain and Ireland: Findings from the Health Behaviour in School Aged Children Survey 2006* (HSBC 2009) at 59 and Gavin et al *Drunkenness Among School children in Ireland* (Research Factsheet No 5 HSBC Ireland 2006).

⁴⁷ Office of Tobacco Control *Children, Youth and Tobacco, Behaviour Perceptions and Public Attitudes* (Office of Tobacco Control, 2008) at 36.

numbers of students smoking, evidenced by the 2007 ESPAD report⁴⁸ however tobacco use remains an issue of concern, particularly for teenage girls⁴⁹.

3.44 Looking at drug use amongst children and adolescents, 16% of children have reported using cannabis during their lifetime, with usage rates highest amongst 15-17 year olds⁵⁰. A more recent report has confirmed these statistics, with a finding that 15.7% of children aged 9-17 have reported using cannabis at least once in their lifetime⁵¹. Research carried out in inner-city Dublin found that drug use was initiated on average at 12 and 13 years of age, an indication of the link between drug use and socio-economic factors.⁵² The 2007 ESPAD report found that lifetime use of cannabis (20%) and other substances (10%) by Irish students was average compared to students from other countries however use of inhalants in Ireland (15%) was more prevalent than other countries.⁵³ A lack of a child focused approach to inform policy on drug usage means that although children are prosecuted for drugs offences, there is no specialist counselling and treatment service for children with drug addiction problems.⁵⁴

(3) Voice of the Child in the Health Care Setting

3.45 Children who suffer from a disease, a chronic illness or a disability, are sometimes viewed differently by their peers. In many ways they are different:

⁴⁸ Hibell et al *The 2007 ESPAD Report: Substance Use among Students in 35 Countries* (ESPAD 2009) at 120-121.

⁴⁹ Nic Gabhainn et al *The Irish Health Behaviour in School Aged Children (HBSC 2006)* (HSBC Ireland 2007) at 21.

⁵⁰ *Ibid.*

⁵¹ *State of the Nation's Children* (Office of the Minister for Children and Youth Affairs 2008) at 138.

⁵² *Maycock Choosers or Losers? Influences on Young People's Choices about Drugs in Inner-City Dublin* (The Children's Research Centre 2000) at 34.

⁵³ Hibell et al *The 2007 ESPAD Report: Substance Use among Students in 35 Countries* (ESPAD 2009) at 108.

⁵⁴ *KilKelly Children's Rights in Ireland* (Tottel Publishing 2008) at 424, Rooney "The Medico-Legal Impact of Consent to Treatment of Under Aged drug Users" (1998) 4 *Medico- Legal Journal of Ireland* 74 at 74.

“In the context of healthcare the reality is that children do not go through the same transitions at the same time.⁵⁵”

3.46 From a young age, they are thrust into the medical domain and undergo a steep learning curve. Children adapt to a routine of hospitals, doctor’s appointments, treatment and medicine. They become familiar and adept at dealing with the health problems and constraints they face on a daily basis. Research has shown how experience of illness enables children to develop the understanding and maturity to take responsibility for their health and to make health care decisions⁵⁶.

3.47 Such personal experiences add greatly to the evolving capacities of children and can place them ahead of their peers in terms of maturity, responsible thinking and decision making. This must be taken into account when treating children and considering health care and treatment options. As discussed in chapter one⁵⁷, Article 12 of the the UN Convention of the Rights of the Child provides:

“State Parties shall assure to the child who is capable of forming his or her own views 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.”

3.48 For children dealing with considerable and permanent health problems, this right takes on an added significance and it is of the utmost importance that these children are fully involved in the management of their medical care. Submissions received during the public consultation on the National Children’s Strategy focused on the experience of the child in hospital, and the need to create a partnership approach encompassing health care professionals, children and parents.

3.49 Article 7 of the UN Convention on the Rights of Persons with Disabilities emphasises the importance of Article 12 of the Convention on the Rights of the Child in the context of children with disabilities:

“State Parties shall ensure that children with disabilities have the right to express their views freely on all matters affecting them, their views

⁵⁵ Logan “The Rights of Children in Healthcare: the Views of the Ombudsman for Children” (2008) 14 (2) *Medico- Legal Journal of Ireland* 66 at 69.

⁵⁶ Alderson et al “Children’s Competence to Consent to Medical Treatment” (2006) *Hastings Centre Report* at 32. Alderson “Competent children? Minors’ Consent to Health Care Treatment and Research” *Social Science & Medicine* (2007) 65 at 2272.

⁵⁷ 1.38.

being given due weight in accordance with their age and maturity, on an equal basis with other children, and to be provided with disability and age-appropriate assistance to realise that right.”

3.50 Bearing in mind the requirements of Articles 12 and 24(1) of the UN Convention on the Rights of the Child 1989, the Commission acknowledges that the right of children to be heard in matters affecting them takes on an added importance when dealing with serious and/or long term health concerns and has provisionally concluded that this should form a guiding principle in its analysis of this area of law.

3.51 *The Commission provisionally recommends that, in recognition of Article 12 of the 1989 UN Convention on the Rights of the Child, a child who is capable of forming his or her own views has the right to express those views freely in all matters affecting him or her and that the views of the child should be given due weight in accordance with his or her age and maturity.*

(4) Adolescent Health Concerns

3.52 Much of the literature on the medical concerns of children is focused on adolescence - a stage of life which is open to various definitions and interpretations. Indeed adolescence can be viewed as a phase rather than a specific age or period in time. The World Health Organisation defines adolescence as a distinct developmental period in the age group of 10-19 year olds.⁵⁸ Regardless of exact definition, it is sufficient to state that all children and young people under the age of 18 will undergo a period of adolescent change and development. This period of change and development is critical, as beliefs and behaviours developed in adolescence can be maintained throughout adulthood and can have a permanent impression on a person's health.

3.53 The importance of the adolescent phase in a health context is well recognised and documented. In 2003, the UN Committee on the Rights of the Child issued a General Comment on *Adolescent Health and Development in the Context of the Convention on the Rights of the Child*⁵⁹. The Comment defined adolescence as:

“a period characterised by rapid physical, cognitive and social changes, including sexual and reproductive maturation; the gradual

⁵⁸ World Health Organisation *Adolescent Friendly Health Services: An Agenda for Change* (WHO/FCH/CAH/02.14 2002) at 5.

⁵⁹ Committee on the Rights of the Child “*Adolescent health and development in the context of the Convention on the Rights of the Child*” (General Comment No 4 of 2003 CRC/GC/2003/4 1 July 2003).

building up of the capacity to assume adult behaviours and roles involving new responsibilities requiring new knowledge and skills.”⁶⁰

3.54 The Committee noted that State parties have not given sufficient attention to the specific concerns of adolescents as rights holders and to the promotion of their health and development.⁶¹ Adolescents need to be recognised as active rights holders who have the capacity to become full and responsible citizens, given the proper guidance and direction. The right to express their views freely and have them taken into account under Article 12 of the Convention on the Rights of the Child is fundamental in realising the rights of adolescent’s to health and development.⁶²

3.55 The World Health Organization has focused on adolescent health needs and challenges, stating that adolescents today face more challenges than previous generations.⁶³ Adolescents are vulnerable to sexually transmitted infections, unplanned pregnancies, alcohol and drug abuse, eating disorders, and mental health problems particularly those who live in countries where adolescents are not viewed as a priority group in terms of health care provision.⁶⁴ Lifestyle decisions made during adolescence can greatly impact on health and mortality in later years. Binge drinking, regular drug use, poor eating habits, lack of exercise, low self esteem and stress are all risk factors which can be associated with an adolescent lifestyle.

3.56 The 2006 report by the Expert Group on Mental Health Policy, *A Vision for Change* emphasised that adolescence is a key stage of psychological development:

“It is a time of increased risk of poor mental health with anxiety, depression, psychosis, eating disorders, and substance misuse becoming more prevalent, as well as an increasing risk of deliberate self harm and suicidal behaviour⁶⁵”

⁶⁰ *Ibid* at 2.

⁶¹ *Ibid* at 3.

⁶² Committee on the Rights of the Child “*Adolescent health and development in the context of the Convention on the Rights of the Child*” (General Comment No 4 of 2003 CRC/GC/2003/4 1 July 2003) at 8.

⁶³ World Health Organisation *Adolescent Friendly Health Services :An Agenda for Change* (WHO/FCH/CAH/02.14 2002) at 3.

⁶⁴ *Ibid* at 4.

⁶⁵ *A Vision for Change: Report of the Expert Group on Mental Health Policy* (Stationary Office 2006) at 86.

3.57 There is a lack of designated facilities for adolescents within the medical setting⁶⁶. This was reflected in the range of submissions received during the consultation for the National Children’s Strategy, which consistently called for dedicated health services for adolescents – “the forgotten population”.⁶⁷ Adolescents are routinely placed in wards with children or elderly adults. These wards do not cater for the needs of adolescents which are different from those of both children and adults⁶⁸. Many adolescents, particularly those with chronic illnesses, have assumed a degree of responsibility for their own health care and treatment, which must be respected within the hospital environment. Adolescents need to be supported during the transition from paediatric to adult services, and encouraged to manage their own illness.⁶⁹ Numerous submissions put forward during the public consultation for the National Children’s Strategy highlighted this issue, and called for flexibility in hospital rules regarding adolescent patients, advocating improved levels of confidentiality and privacy.

3.58 Confidentiality is extremely important to adolescents⁷⁰. Paragraph 11 of the Comment on *Adolescent Health and Development in the Context of the Convention on the Rights of the Child*⁷¹ builds on Article 16 of the Convention of the Rights of the Child, which protects young people’s rights to privacy.⁷² Paragraph 11 states that:

“Health-care providers have an obligation to keep confidential medical information concerning adolescents, bearing in mind the

⁶⁶ *Get Connected: Developing an Adolescent Friendly Health Service* (National Conjoint Child Health Committee 2001) at 10.

⁶⁷ *Report of the Public Consultation: National Children’s Strategy* (Stationary Office 2000) at 89.

⁶⁸ *An Outline Guide for the Provision of Healthcare Services to Children and Young People* (Children in Hospital Ireland 2002) at 15.

⁶⁹ *Get Connected: Developing an Adolescent Friendly Health Service* (National Conjoint Child Health Committee 2001) at 11.

⁷⁰ See comments of the participants of the Consultation Day at 1.65.

⁷¹ Committee on the Rights of the Child “*Adolescent health and development in the context of the Convention on the Rights of the Child*” (General Comment No 4 of 2003 CRC/GC/2003/4 1 July 2003).

⁷² Article 16 (1) “No child shall be subject to arbitrary or unlawful interference with his or her privacy, family, or correspondence, nor to unlawful attacks on his or her honour and reputation.” (2) “The child has the right to the protection of the law against such interference and attacks”.

basic principles of the Convention. Such information may only be disclosed with the consent of the adolescent, or in the same situations applying to the violation of an adult's confidentiality. Adolescents deemed mature enough to receive counselling without the presence of a parent or other person are entitled to privacy and may request confidential services, including treatment."⁷³

3.59 Furthermore, States should enact laws or regulations which stipulate that advice given to adolescents is confidential, in order to enable them to make an informed consent.⁷⁴ Such laws and regulations should specify an appropriate age for this process, or refer to the evolving capacities of the child. The Comment also states that training should be provided for health personnel on the rights of adolescents to privacy, confidentiality, to information about planned treatment, and their right to give informed consent to treatment⁷⁵.

3.60 The 2009 Guide to Professional Conduct and Ethics issued by the Medical Council of Ireland states that confidentiality is a fundamental principle of medical ethics, central to the trust between patients and doctors. Thus, when treating children and young people, health care professionals should remember their duties of confidentiality, subject to parental rights of access to medical records which may arise by law.⁷⁶ This indicates that there is no guarantee of confidentiality. It is not clear in this respect what age group the guidance is referring to. Presumably young people aged 16-18, who are entitled by law to consent to medical treatment would have their confidentiality respected.

Mental Health⁷⁷

3.61 Adolescence, a time of rapid development, is a typical time for the onset of a variety of mental disorders which can have long-lasting implications⁷⁸. Adolescents from all social classes and backgrounds can develop a mental

⁷³ Committee on the Rights of the Child "*Adolescent health and development in the context of the Convention on the Rights of the Child*" (General Comment No 4 of 2003 CRC/GC/2003/4 1 July 2003) at 11.

⁷⁴ *Ibid* at 32.

⁷⁵ *Ibid* at 33.

⁷⁶ The Medical Council *Guide to Professional Conduct and Ethics For Registered Medical Practitioners* (7th ed 2009) at 41.

⁷⁷ Mental health is discussed in detail in Chapter 6.

⁷⁸ Molcho et al *Social cohesion for mental well being in adolescence* (World Health Organisation/HBSC Forum 2007 2008) at 133. *A Vision for Change: Report of the Expert Group on Mental Health Policy* (Stationary Office 2006) at 86.

health disorder however certain adolescents are more at risk due to factors such as parental mental illness, family breakdown, abuse, learning disability, bereavement and substance abuse⁷⁹. Adolescents sometimes face a clash of personalities in their home and familial environment which can lead to disruptive behaviour and the development of mental health problems. Disruptive and problematic behaviour, however, can be the product of misunderstanding and hostility rather than an inherent mental health issue.

3.62 The National Economic and Social Forum published a report on *Mental Health and Social Inclusion* in 2007, stating that young people were a huge demographic group, vulnerable to mental ill-health and suicide. The report highlighted the need for urgent action, as early intervention and support can make a difference. The report also referred to the current barriers of access to services for young people, which can be overcome⁸⁰.

Sexual Health

3.63 The link between adolescence and sexual health is well documented. The World Health Organisation has highlighted the issue on numerous occasions, referring to adolescent sexual health as one of the most important health-care issues of the twenty-first century.⁸¹

3.64 It is important to note that, while not all adolescents are sexually active, there has been a rise in sexual activity among young people in Ireland. It is difficult to access precise statistics regarding sexual activity amongst young people however there are indications that a substantial proportion of the adolescent population in Ireland are sexually active. Furthermore, there seems to have been a drop in the age of first time intercourse. Statistics used by the Irish Family Planning Association indicate that between 20 and 50% of young

⁷⁹ *Get Connected: Developing an Adolescent Friendly Health Service* (National Conjoint Child Health Committee 2001) at 23.

⁸⁰ National Economic Social Forum *Mental Health and Social Inclusion* (NESDO, Report 36 October 2007) at 168. <http://www.nesf.ie/dynamic/pdfs/No-36-Mental-Health-Social-Inclusion.pdf>

⁸¹ World Health Organisation *Contraception: Issues in Adolescent Health and Development* (Department of Child and Adolescent Health and Development World Health Organisation 2004) at 1. Tripp "Sexual Health, Contraception and Teenage Pregnancy" (2005) 230 *British Medical Journal* 590.

people in Ireland report having sexual intercourse before the age of 17⁸², the legal age of consent.⁸³

3.65 Statistics vary according to geographical location and socioeconomic circumstances, however the Irish Family Planning Association feel that similar levels of sexual activity are evident across the country, and young people face similar concerns, regardless of geographic location. A study published in 2003 found that 12% of college students had sexual intercourse before the age of 16. An earlier study carried out amongst youths in Cork city revealed that 22% of females and 32% of males had intercourse before the age of 16. A survey carried out in 1997 revealed that 21% of 15-18 year olds in Galway city and county have had intercourse⁸⁴. Another survey, also conducted in 1997 found that half of the participants surveyed, aged 17-20 years of age, had intercourse before the age of 16⁸⁵. A research report published in 2007 indicated that a third of 16 year old school goers may be sexually active⁸⁶.

3.66 Regardless of the exact figures, it is clear that a significant number of Irish adolescents are sexually active from a young age. The legal age of consent does not appear to be used as a guide or benchmark by young people contemplating initial sexual intercourse⁸⁷. This is partially recognised by the *Criminal Law (Sexual Offences) Act 2006*, and the requirement that the consent of the Director of Public Prosecutions is needed to prosecute those engaging in sexual intercourse before the age of consent.⁸⁸ Several agencies and interest

⁸² See Hyde and Howlett *Understanding Teenage Sexuality* (Crisis Pregnancy Agency Report No. 9 2004) at 19.

⁸³ Section 2 of the *Criminal Law Amendment Act 1935*.

⁸⁴ *Get Connected: Developing an Adolescent Friendly Health Service* (National Conjoint Child Health Committee 2001) at 73. Mc Hale and Newell "Sexual behaviour and sex education in Irish school going teenagers" (1997) 8 *International Journal of STD and Aids* 196.

⁸⁵ Hyde and Howlett *Understanding Teenage Sexuality* (Crisis Pregnancy Agency Report No. 9 2004) at 19.

⁸⁶ See discussion in Maycock et al *Relationships and Sexuality Education in the Context of Social, Personal and Health Education: An Assessment of the Challenges to Full Implementation of the Programme in Post-primary Schools Summary Report* (Crisis Pregnancy Agency 2007) at 9.

⁸⁷ Maycock and Byrne *A Study of Sexual health Issues, Attitudes and Behaviours: The Views of Early School Leavers* (Crisis Pregnancy Agency Report No. 8 2004) at 68.

⁸⁸ Section 3(9) of the *Criminal Law (Sexual Offences) Act 2006*.

groups have denounced the criminalisation of consensual sexual activity between adolescents under the age of 17, and feel that the sexual abuse of minors should be criminalised in a separate piece of legislation⁸⁹.

3.67 The average age of initial sexual intercourse has fallen sharply in several parts of the industrialised world such as England, Germany, France Finland, Denmark and the United States, with Ireland also witnessing this downward trend⁹⁰. The Crisis Pregnancy Agency has carried out a substantial body of research on adolescent sexual activity, stating that:

“Adolescents are negotiating sexual encounters and sexual intimacies at an increasingly young age, with a greater burden of individual decision making resting with the young person”⁹¹.

3.68 The most recent HSBC report contained a section on sexual health behaviours, although Irish participants were not included. The findings from England, Scotland and Wales indicate that between 28.8-35.6% of 15 year olds reported having had sex.⁹² Factors such as family affluence did not have any significant impact on statistics.

3.69 Early age of sexual activity has been linked to non-use of contraception⁹³. Young people are less likely to use contraception regularly, often making their first visit to a health care professional or sexual health service at a time of crisis.⁹⁴ A survey carried out by the Crisis Pregnancy Agency published in 2004, revealed that teenage participants were uneasy about using health services and used various strategies to have their needs for

⁸⁹ For an overview of the *Criminal Law (Sexual Offences) Act 2006* see O Gara “Protecting Young Girls From Themselves-Part Three: Reform in Ireland” (2007) 25 *Irish Law Times* 221.

⁹⁰ UNICEF Innocenti Report Card Issue No 3 *A League Table of Teenage Births in Rich Nations* (United Nations Children’s Fund 2001) at 12.

⁹¹ Hyde and Howlett *Understanding Teenage Sexuality* (Crisis Pregnancy Agency Report No. 9 2004) at 11. See also Fullerton *Promoting Positive Adolescent Sexual Health & Preventing Teenage Pregnancy* (Crisis Pregnancy Agency Report No.2 2004).

⁹² Brooks et al *Young People’s Health in Great Britain and Ireland :Findings from the Health Behaviour in School Aged Children Survey 2006* (HSBC 2009) at 44.

⁹³ Hyde and Howlett *Understanding Teenage Sexuality* (Crisis Pregnancy Agency Report No. 9 2004) at 21.

⁹⁴ *Ibid* at 22.

contraception met⁹⁵. A considerable proportion of participants in the survey experienced limited access to accurate and reliable information about contraception in general, which reflected a lack of trust in those around them not to reveal information to their parents⁹⁶. Young women revealed significant difficulties in accessing the contraceptive pill, and were uncertain at what age they could be prescribed contraception without parental knowledge or consent, with some participants lying about their age and the reason why they wished to be prescribed a contraceptive pill. Confidentiality and anonymity were key concerns, particularly for those living in rural areas⁹⁷.

3.70 The teenage pregnancy rate in Ireland remained relatively stable between 1991 and 2005, reaching a high of 25.7 per 1,000 females aged 15-19 in 1991.⁹⁸ The majority of teenagers who fall pregnant are aged 17-19, with few aged below 15.⁹⁹ Geographical variations can be observed, however the lack of statistics on teenage fertility and pregnancies makes it difficult to draw comparisons with other countries or pinpoint particular areas of concern¹⁰⁰.

3.71 There is broad consensus internationally that young people must have access to clear information on sexual health.¹⁰¹ The ineffective and piecemeal approach to sex education in Ireland, both inside and outside the school system has been documented¹⁰². There are serious gaps in young people's knowledge regarding sexual health.¹⁰³ Research has indicated that

⁹⁵ Hyde and Howlett *Understanding Teenage Sexuality* (Crisis Pregnancy Agency Report No. 9 2004) at 10.

⁹⁶ *Ibid* at 81.

⁹⁷ Hyde and Howlett *Understanding Teenage Sexuality* (Crisis Pregnancy Agency Report No. 9 2004) at 82.

⁹⁸ O Keefe et al *Crisis Pregnancy Agency Statistical Report 2006: Revised Teenage Pregnancy Data* (Crisis Pregnancy Agency 2006) at 16.

⁹⁹ *Ibid* at 8.

¹⁰⁰ Hyde and Howlett *Understanding Teenage Sexuality* (Crisis Pregnancy Agency Report No. 9 2004) at 27.

¹⁰¹ KilKelly *Children's Rights in Ireland* (Tottel Publishing 2008) at 430.

¹⁰² Hyde and Howlett *Understanding Teenage Sexuality* (Crisis Pregnancy Agency Report No. 9 2004) at 40- 47.

¹⁰³ Maycock and Byrne *A Study of Sexual Health Issues, Attitudes and Behaviours: the views of early school leavers* (Crisis Pregnancy Agency Report No.8 2004), Hyde and Howlett *Understanding Teenage Sexuality* (Crisis Pregnancy Agency Report No. 9 2004) at 27.

communication with parents can help delay the age of first intercourse and increase the use of contraception. However it seems that most young people do not discuss sex with their parents or guardians, and rely on friends and the media for information¹⁰⁴. The lack of accurate and appropriate information and advice for young people is particularly alarming when one considers the consistent rise of sexually transmitted infections in Ireland, representing an increase of 298% from 1989 to 2000.¹⁰⁵

3.72 Paragraph 28 of the Comment on *Adolescent Health and Development in the Context of the Convention on the Rights of the Child* clearly states that adolescents must receive adequate and specific information on sexual and reproductive health, regardless of whether or not their parents consent¹⁰⁶. The Committee on the Rights of the Child specifically recommends that States play a pro-active role in the prevention of STD's and early teenage pregnancies by implementing programmes which include access to contraception and family planning¹⁰⁷.

3.73 In its evaluation of Ireland's implementation of the Convention on the Rights of the Child, the UN Committee on the Rights of the Child raised concerns in relation to sexual health of children and young people and their access to information. The Committee noted that the minimum legal age for consulting a doctor without parental consent was 16 years, and questioned where children and young people below the age of 16, who had sexual or drugs-related problems could go to talk to a doctor or a psychologist without informing their parents. The question seems to have been avoided, as the Irish delegation could not give a satisfactory answer.¹⁰⁸ The Committee expressed concern at the poor access to education and health services.

¹⁰⁴ Hyde and Howlett *Understanding Teenage Sexuality* (Crisis Pregnancy Agency Report No. 9 2004) at 16, 33.

¹⁰⁵ *Ibid* at 25.

¹⁰⁶ Committee on the Rights of the Child "*Adolescent health and development in the context of the Convention on the Rights of the Child*" (General Comment No 4 of 2003 CRC/GC/2003/4 1 July 2003).

¹⁰⁷ *Ibid* at 31.

¹⁰⁸ Kilkelly "In the Best Interests of the child? An evaluation of Ireland's Performance before the UN Committee on the Rights of the Child" (1998)16 *Irish Law Times* 293 at 299. See also

[http://www.unhcr.ch/tbs/doc.nsf/\(Symbol\)/a021975440ef9258802565a90035bdbc?Opendocument](http://www.unhcr.ch/tbs/doc.nsf/(Symbol)/a021975440ef9258802565a90035bdbc?Opendocument)

D The Mature Minor – Access to Medical Advice and Treatment

3.74 The issue of the capacity of a person under the age of 18 to consent to medical treatment has arisen in many countries in the specific context of the provision of contraceptive advice and medical treatment to prevent pregnancy. This has given rise to litigation (such as the *Gillick*¹⁰⁹ case in England) and legislation, to set out the extent of the capacity of a person under the age of consent in criminal law to medical treatment in that context.¹¹⁰

(a) Availability of contraception

3.75 UNICEF has concluded that achieving a reduction in the teenage birth rate is based on improving accessibility to contraception and appropriate sex education, which enables teenagers to make informed and educated decisions.¹¹¹ As mentioned above, young people have limited access to clear and appropriate information and sex education.

3.76 It is difficult to gauge the precise nature or type of access that Irish children have to contraception. Health care professionals are, in essence, caught in a legal vacuum because the age of consent in criminal law for sexual intercourse is 17 years. They are thus uncertain regarding the interaction between the legal age of consent, the age of consent to medical treatment, ethical principles of confidentiality and their responsibility to act in the best interests of the patient. The Irish Family Planning Association has highlighted the uncertainty and reluctance on behalf of doctors to deal with minors who request sexual and reproductive advice and treatment. There are no guidelines on how a health care professional should advise and care for an adolescent seeking contraceptive treatment and advice. Such ambiguity has an adverse effect on young people who are reluctant to seek treatment and are putting their health at risk by engaging in unsafe sexual practices. The Crisis Pregnancy Agency confirmed the difficulties young people face in obtaining advice and treatment.

3.77 Condoms are available via vending machines and shops, and young people aged 16 years of age can consent to medical treatment, which

¹⁰⁹ *Gillick v West Norfolk and Wisbech Health Authority* [1985] 3 All ER402.

¹¹⁰ *The Criminal Law Amendment Act 1935* set the age of consent at 17 years of age. Across Europe ages range from 12 to 18 years of age. See Graupner “Sexual Consent: The Criminal Law in Europe and Overseas” (2000) 29(5) *Archives of Sexual Behaviour* 415.

¹¹¹ UNICEF Innocenti Report Card Issue No 3 *A League Table of Teenage Births in Rich Nations* (United Nations Children’s Fund 2001) at 25.

presumably covers prescriptive contraceptives. Section 23(1) of the *Non-Fatal Offences Against the Person Act 1997* states:

“The consent of a minor who has attained the age of 16 years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his or her person, shall be as effective as it would be if he or she were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his or her parent or guardian”

3.78 Section 23 and its implications are discussed in detail in Chapter 4¹¹². For present purposes, it is sufficient to state that a 16 year old may consent to medical treatment. However the Irish Family Planning Association has stated that some doctors are reluctant to prescribe contraceptives to anyone under the age of 17, and there have been incidents where a doctor has breached the confidentiality of the patient in question by informing the patient’s parents. There have also been situations where a health care professional has reported the incident to the Gardai Síochána or the Health Service Executive as a potential criminal act. The provision of contraceptives to a person under 17 years of age, however, is not illegal. Under section 4 of the *Health (Family Planning) (Amendment) Act 1992*, contraceptives may be sold to a person if they are named in a prescription, in writing, by a registered medical practitioner.¹¹³

3.79 The legal position of doctors regarding the prescription of contraceptives to females aged below 16 or 17 years of age has never been challenged¹¹⁴. The law in this area is particularly unclear, as section 23 of the 1997 Act does not explicitly prohibit children under the age of 16 from consenting to medical treatment. It is probable that doctors, using their discretion in the best interests of the patient, prescribe contraceptives to females aged below 16 years of age. There have been reports of doctors facing

¹¹² 4.02.

¹¹³ Section 2 of the *Health (Family Planning) (Amendment) Act 1993* –‘contraceptive’ means any appliance or instrument, excluding contraceptive sheaths prepared or intended to prevent pregnancy resulting from sexual intercourse between human beings.

Section 4(1)(b)(ii) of the *Health (Family Planning) (Amendment) Act 1992* –“the person to whom the contraceptives are sold is over the age of 17 years or married or is named in a prescription or authorisation in writing for the contraceptives of a registered medical practitioner.”

¹¹⁴ Donnelly “Capacity of Minors to Consent to Medical and Contraceptive Treatment” (1995) 1 *Medico Legal Journal of Ireland* 18.

increasing requests from females under the age of 16 for the morning-after pill or the contraceptive pill¹¹⁵.

3.80 Contraception is regulated by prescription and constitutes a form of medical treatment, but is more often considered as a social issue rather than a medical or legal concern. The social ramifications and public scrutiny of any legislation or regulation regarding contraception, particularly to those aged less than 17 years of age, is obvious. Any scheme to regulate children's access to contraceptive treatment must seek to occupy a middle ground position, which does not condone early sexual activity whilst ensuring that young people have access to necessary medical treatment.

(b) The development of "mature minor" rules

3.81 The development and operation of mature minor rules in England, Scotland, Australia, Canada and New Zealand are discussed in detail in Chapter 4, as the present discussion is focused on sexual and reproductive health¹¹⁶.

(i) UK: The Gillick case and the mature minor rule

3.82 The decision of the House of Lords in *Gillick v West Norfolk and Wisbeck Health Authority 1986*¹¹⁷ has been described as the most significant of the 20th century on the legal relationship between parents and children.¹¹⁸ It greatly influenced the expansion of the mature minor rule, which has been developed in Australia, New Zealand and Canada.

3.83 The case arose as a response to a circular issued by the English Department of Health and Social Security which stated that a doctor would not be acting unlawfully if he or she, acting in good faith, prescribed contraceptives to a girl under the age of 16 to protect her from the harmful effects of sexual intercourse. The claimant was a mother of 5 daughters under the age of 16 who sought assurances from her local health authority that her daughters would not receive contraceptive advice without her consent. She also sought a declaration that the advice contained in the circular was unlawful as it breached her parental rights. The claimant argued that the circular advised doctors to commit an offence by encouraging unlawful intercourse with a girl under the age of 16, contrary to sections 6 and 28 of the English *Sexual Offences Act 1956*. The claimant lost at first instance but was successful in the English Court of Appeal.

¹¹⁵ The Irish Times "Surge in girls seeking morning after pill" 18/04/2009.

¹¹⁶ 4.19.

¹¹⁷ 3 All ER402.

¹¹⁸ Bainham *Children and the Modern Law* (3rd ed Family Law 2005) at 346.

The case was then brought before the House of Lords.¹¹⁹ By a majority of 3-2, the House of Lords found in favour of the health authority and rejected the argument that children under 16 years of age could not consent to medical advice or treatment.

3.84 The complexity involved in prescribing contraception to a minor who is not deemed old enough, in the eyes of the law, to consent to sexual intercourse, was discussed by the House of Lords. The majority judges rejected the submission that a doctor who provided contraceptive advice and treatment to a girl under 16 would be committing a criminal offence by aiding and abetting the commission of unlawful sexual intercourse. Lord Fraser focused on the intention of the doctor – if the doctor’s intention was to act in the best interests of the patient in question, the doctor would not be committing a crime. Moreover, if doctors were criminalised for prescribing contraception, parents who consent to contraceptive treatment on behalf of their daughters could be faced with the accusation of criminal wrongdoing. Lord Fraser also referred to the fact that under criminal law, a girl under 16 years of age who has sexual intercourse does not commit an offence herself, rather her partner does¹²⁰.

3.85 Lord Scarman, in agreement with Lord Fraser, also emphasised the intention of the doctor in question, and stated that contraceptive treatment could only be prescribed to a female under the age of 16 if she has the capacity to consent or if exceptional circumstances exist which justify a doctor in exercising his clinical judgement without parental consent. The doctor must make a medical judgement based on what he honestly believes to be necessary for the physical, mental and emotional health of the patient.¹²¹

3.86 Lord Bridge spoke of the public policy aspect underlying the criminal sanction regarding men who engage in sexual intercourse with females under 16 years of age. The policy consideration underlying the criminal sanction is the protection of young girls from the untoward consequences of intercourse, such as pregnancy, possibly resulting in abortion or the birth of a child to an immature or irresponsible mother. It would, therefore be contrary to public policy to criminalise the provision of contraception to females under the age of 16.¹²²

3.87 The minority opinions in *Gillick* revealed an opposing view to the legality of prescribing contraceptives to a female under the age of 16. Lord Brandon stated that to advise a female under the age of 16 on contraceptive

¹¹⁹ The Supreme Court.

¹²⁰ Lord Fraser at 413. See *Sexual Offences Act 1956*.

¹²¹ Lord Scarman at 425.

¹²² Lord Bridge at 428.

matters and to prescribe contraception involves the promotion, encouragement or facilitation of sexual intercourse, contrary to public policy, by that girl with a man. Lord Brandon dismissed the reasoning that girls under the age of 16 will have sexual intercourse regardless of the impeded access to contraception, stating:

“if all a girl under 16 needs to so in order to obtain contraceptive treatment is to threaten that she will go ahead with, or continue, unlawful sexual intercourse with a man unless she is given such treatment, a situation tantamount to blackmail will arise which no legal system ought to tolerate. The only answer which the law should give to such a threat is ‘wait till you are 16’.”¹²³

3.88 Lord Brandon’s view of the law was that any prescription of contraception to a female under 16 years of age is illegal, regardless of parental knowledge and consent.

3.89 Lord Templeman, although in agreement with Lord Brandon on several points, differed on the issue of contraceptive treatment where parental consent is forthcoming. He stated that although the criminal law is aimed at preventing unmarried girls under the age of 16 from having sexual intercourse, if a girl cannot be deterred, then contraceptive facilities may be provided. However, Lord Templeman was of the view that a doctor may only prescribe contraception if there is parental consent. Where doctor and parent are in agreement that contraceptive treatment is in the best interests of the patient in question, there is no legal bar to the treatment. Without parental consent however, a girl aged less than 16 years of age should not be able to access contraception.

“There are many things which a girl under 16 needs to practice but sex is not one of them”¹²⁴.

3.90 The views put forward by the minority are understandable; indeed many would agree that it is not in the best interests of young people to engage in sexual intercourse at an early age. However, this is to ignore the changes which have occurred in society and the fact that there is a proportion of the teenage population who are engaging in sexual intercourse. Lord Fraser referred to the importance of acknowledging that societal attitudes and customs change,¹²⁵ with Lord Scarman stating that:

¹²³ Lord Brandon at 430.

¹²⁴ Lord Templeman at 432.

¹²⁵ Lord Fraser at 411.

“The law ignores these developments at its peril¹²⁶.”

3.91 In relation to the issue of consent to contraceptive treatment by children under 16 years of age, Lord Fraser set out a number of guidelines which should apply in this respect:

“The doctor will, in my opinion, be justified in proceeding without the parents consent or even knowledge provided he is satisfied on the following matters:

1. that the girl (although under 16 years of age) will understand his advice
2. that he cannot persuade her to inform her parents or to allow him to inform the parents that she is seeking contraceptive advice
3. that she is very likely to begin or to continue having sexual intercourse with or without contraceptive treatment
4. that unless she receives contraceptive advice or treatment her physical or mental health or both are likely to suffer
5. that her best interests require him to give her contraceptive advice, treatment or both without parental consent.¹²⁷”

3.92 These factors, often referred to as the “Fraser Guidelines” are widely followed in England by health care professionals in the context of contraceptive advice, and have also formed the basis for comparable mature minor guidance in other States.

3.93 Following the *Gillick* case, the legal position in England is that a person aged 16 years can consent to medical treatment, without parental consent or involvement. A person aged less than 16 years of age is subject to the mature minor rule, which means that a minor can consent to medical treatment if he or she fully understands the consequences of the treatment. Practically speaking, the assessment of the minor’s maturity and the decision regarding the minor’s level of comprehension rests with the doctor.

3.94 The Fraser guidelines are followed as best practice in England regarding the provision of contraception to young people under the age of 16, as set out in the 2004 Department of Health guidelines¹²⁸. The guidelines clearly

¹²⁶ Lord Scarman at 419.

¹²⁷ Lord Fraser at 413.

¹²⁸ *Best Practice Guidance for Doctors and other Health Professionals on the Provision of Advice and Treatment to Young People under 16 on Contraception, Sexual and Reproductive Health* (Department of Health 2004).

state that doctors and health care professionals have a duty of care and confidentiality to all patients, including young people under the age of 16. Young people under 16 years of age are the group least likely to use contraception and concern about confidentiality is the main deterrent to seeking advice and treatment¹²⁹. The guidelines seek to reassure young people under the age of 16 by clearly stating that they have the same right to confidentiality as adults. There may be circumstances however, where this right is not absolute therefore if a health care professional believes there is a risk to the health, safety or welfare of a young person or others which is so serious as to outweigh the young person's right to privacy, they should follow child protection protocols.

3.95 A challenge to the legality of the 2004 Department of Health guidelines came before the courts in *R (Axon) v Secretary of State for Health*.¹³⁰ The circumstances were similar to those in *Gillick* and the case was based on a challenge to the duty of confidentiality owed to children seeking advice on sexual matters, including abortion. The claimant argued that guidelines which stated that children under 16 years of age are owed the same duty of confidentiality as any other person interfered with her rights and responsibilities as a parent, and were also incompatible with the *Gillick* case. Furthermore, it was argued that the guidelines were incompatible with Article 8(1) of the European Convention on Human Rights¹³¹.

3.96 In the English High Court, Silber J outlined the tension caused by two competing principles¹³². The first principle is that of the competent young person, an autonomous being, who is entitled to confidentiality and should be allowed to make decisions about his or her health. The second principle concerns the parent with responsibility for the health and welfare of the young person, who should be informed if a medical professional is providing advice and treatment on sexual health to the young person. Silber J also spoke of the significant public policy dimension which plays a part, referring to evidence which indicates that without a guarantee of confidentiality, young people will not seek advice or treatment from medical professionals which may lead to adverse consequences.

3.97 It was noted at the outset that the application was concerned with young people who would not be persuaded to notify their parents or let the medical professional inform them. Silber J stated that there was nothing in his

¹²⁹ *Ibid.*

¹³⁰ [2006] EWHC 37 (Admin).

¹³¹ Article 8 "Everyone has the right to respect for his private and family life, his home and his correspondence...."

¹³² Silber J at 7.

judgement which was intended to encourage young people to seek or obtain advice or treatment without first informing their parents and discussing the situation with them. In the overwhelming majority of cases, the best judges of a young person's welfare are his or her parents.

3.98 The claimant outlined the obligation owed by a parent to a child under the *Children Act 1989*, stating that parents have a duty to protect their children and to guide them on various issues including health and social issues. Disclosure to parents by a medical professional would therefore be justified in the public interest, by enabling parents to fulfil their duties and responsibilities. This public interest would outweigh the private interest of young people to have their confidentiality respected¹³³. Silber J, while accepting the relevance of the "family factor considerations" advanced by counsel for the claimant, rejected the argument that the guidance was in conflict with *Gillick*. He concluded that the House of Lords had clearly decided that a doctor could lawfully give advice to a competent minor without parental knowledge. Furthermore, the claimant's argument was contrary to the high duty of confidentiality applicable in the context of medical information, the legal rights of young people, and international principles of human rights which require respect for the autonomy of young people¹³⁴. Competent children are entitled to the same duty of confidentiality as adults and there is a strong public interest in the maintenance of confidences, particularly in the context of young people seeking advice on matters of sexual health.

3.99 The claimant based part of the challenge on the *UK Human Rights Act 1998*, arguing that the guidelines constituted an interference with her rights under Article 8 of the European Convention of Human Rights. Silber J stated that the right to parental control derived from Article 8 is a dwindling right which exists for the benefit of the child. Furthermore, any interference with parental rights could be justified under Article 8(2) as necessary to protect the health or rights of others.

3.100 Silber J emphasised that young people are reluctant to seek medical support unless they are certain that their confidentiality will be respected, referring to the period of time between the decision of the Court of Appeal in *Gillick* and the final decision in the House of Lords. During this period, the Department of Health advised medical professionals not to prescribe contraceptives to young people under the age of 16 without parental consent.

¹³³ *Ibid* at 44. See Bridgeman "Young People and Sexual Health: Whose Rights? Whose Responsibilities?" (2006) 14 *Medical Law Review* 418 at 421.

¹³⁴ See Taylor "Reversing the Retreat from *Gillick*? R (Axon) v Secretary of State for Health" (2007) 19(1) *Child & Family Law Quarterly* 81 at 84.

This caused a striking reduction in the number of young women under the age of 16 who sought advice on contraception:

“statistics provide clear and powerful evidence of what happens when young people are not assured of confidentiality when they are considering obtaining advice and treatment on sexual matters. There is additionally cogent evidence that doctors clearly appreciate the importance of confidentiality to young people who are considering seeking guidance on sexual matters.”¹³⁵

3.101 Silber J reiterated five requirements, based on the *Gillick* case, which must be met before advice and treatment in relation to sexual health is provided by a medical professional to a young person under 16 years of age:

- (1) That the young person although under 16 years of age understands all aspects of the advice, including all relevant matters such as family and moral matters as well as all possible adverse consequences which might follow from the advice
- (2) That the medical professional cannot persuade the young person to inform his or her parents or to allow the medical professional to inform the parents that their child is seeking advice and/or treatment on sexual matters
- (3) In the case of contraception or treatment for sexually transmitted diseases, the young person is very likely to begin or continue having sexual intercourse
- (4) Unless the young person receives advice and treatment on the relevant sexual matters, his or her physical or mental health or both are likely to suffer
- (5) That the best interests of the young person require him or her to receive advice and treatment on sexual matters without parental consent or notification

3.102 The *Axon* case has been seen as a clear affirmation of *Gillick* and an explicit recognition of the decision making rights of young people¹³⁶.

(ii) Scotland

3.103 In 1987 the Scottish Law Commission published a *Report on the Legal Capacity and Responsibility of Minors and Pupils*, which was largely

¹³⁵ At 69.

¹³⁶ Taylor “Reversing the Retreat from *Gillick*? R (Axon) v Secretary of State for Health” (2007) 19(1) *Child & Family Law Quarterly* 81 at 93.

implemented by the *Age of Legal Capacity (Scotland) Act 1991*, discussed in chapter 4¹³⁷. The Scottish Law Commission agreed with concerns expressed by commentators that any change in the law should not restrict young people's access to contraceptive advice and treatment. The Commission stated that although parental involvement is clearly desirable when such treatment is sought, it is not always possible.¹³⁸

(iii) Australia

3.104 The High Court of Australia adopted the mature minor rule as set out in the *Gillick* case in *Secretary, Dept of Health and Community Services v JWB and SMB 1992*.¹³⁹ The case involved a dispute over the sterilisation of a 14 year old girl with significant intellectual disabilities. Legislation on the capacity of minors to consent to medical treatment has been enacted in New South Wales and South Australia; in other Australian states and territories competency to consent to medical treatment is regulated by common law, as set out by the High Court of Australia.¹⁴⁰

3.105 The Law Reform Commission of Western Australia, the Queensland Law Reform Commission, and more recently, in 2008, the New South Wales Law Reform Commission have examined the issue of young people's consent to medical treatment, including access to and the availability of contraception.

3.106 The Law Reform Commission of Western Australia published a discussion paper in 1988, referring to evidence which indicated that minors have a great need for contraceptive advice and treatment.¹⁴¹ The Commission recommended that the general rules governing a minor's ability to consent to medical treatment should cover contraceptive advice and treatment, and provisionally recommended a statutory scheme to that effect¹⁴².

3.107 In 1996, the Queensland Law Reform Commission published a report *Consent to Health care of Young People*. The report contained a detailed

¹³⁷ 175 CLR 218.

¹³⁸ Scottish Law Commission *Report on the Legal Capacity and Responsibility of Minors and Pupils* (Report 110 1987) at 3.66.

¹³⁹ 175 CLR 218.

¹⁴⁰ See Chapter 4 at 4.76 for further discussion.

¹⁴¹ Law Reform Commission of Western Australia *Medical Treatment for Minors* (Discussion Paper Project 77 1 1988) at 52.

¹⁴² The reference of the project was withdrawn in 1988. No recommendations had been made by the Commission upon that reference. [http://www.lrc.justice.wa.gov.au/2publications/summaries/P77\(1\).PDF](http://www.lrc.justice.wa.gov.au/2publications/summaries/P77(1).PDF)

discussion on contraceptive health care and referred to various submissions received by the Commission. Most submissions were related to the question of whether there should be any restrictions on a minor's ability to obtain contraceptive health care without parental consent or involvement. The Commission acknowledged that condoms are available freely in supermarkets and vending machines, without any restriction or age limit. To impose restrictions or age limits on prescriptive contraceptives would, in practice, only affect females and could deny them access to contraception. Furthermore:

“It is unlikely that a restriction on the current or future availability of contraceptive advice, information and products to young people will alter their perceptions and practices relating to sexual relations.”¹⁴³

3.108 The Commission stated that there should be no significant legal restrictions on the ability of young people to obtain contraceptive advice and treatment. Rather, a minor should be entitled to consent to contraceptive health care if the requested treatment is in his or her best interests¹⁴⁴.

3.109 In 2008 the New South Wales Law Reform Commission published a report *Young People and Consent to Health Care* recommending the introduction of legislation to regulate the decision-making process regarding health care for young people.¹⁴⁵ The New South Wales Commission acknowledged that the rapid nature of change and turbulence associated with adolescence is often marked by conflict between parent and adolescent.

“The overarching principle guiding the Commission is that the law should not impede the young person's timely access to quality health care.”¹⁴⁶

3.110 The New South Wales Commission felt that all young people should have access to certain treatments without parental consent, regardless of competency to consent. Such treatment would include contraception, treatment for sexually transmitted diseases and treatment for drug and alcohol and abuse. The treatment must be in the best interests of the young person. A panel of experts could identify the special treatments which would be listed in the legislation.

¹⁴³ Queensland Law Reform Commission *Consent to Health care of Young People: Volume One* (Report 51 1996) at 128.

¹⁴⁴ The draft legislation has not been enacted to date.

¹⁴⁵ New South Wales Law Reform Commission *Young People and Consent to Health Care* (Report 119 2008).

¹⁴⁶ *Ibid* at 171.

3.111 The New South Wales Report referred to various surveys, noting that without access to contraceptive advice and prescription, teenagers are at great risk of unwanted pregnancies, and can contract sexually transmitted diseases.¹⁴⁷ Moreover, the majority of submissions received by the New South Wales Commission argued that the requirement for parental consent deters many young people from seeking treatment¹⁴⁸. The Commission agreed that in cases involving contraceptive advice and prescription, and the treatment of sexually transmitted diseases, it is in the best interests and health of the young person to dispense with the requirement for parental consent¹⁴⁹.

3.112 As mentioned above, New South Wales and South Australia have enacted legislation to deal with the issue of minor's consent to medical treatment. These provisions are discussed in more detail in Chapter 4¹⁵⁰. For present purposes, it is sufficient to note that the New South Wales provision is similar to section 23 of the *Non-Fatal Offences against the Person Act 1997* and is limited to protecting medical practitioners as opposed to recognising the capacity of minors to consent to medical treatment.

3.113 The legislative scheme enacted in South Australia, the *Consent to Treatment and Palliative Care Act 1995* is much broader and deals with the rights of minor's and adults to make decisions regarding their medical and palliative care. The Act provides a statutory framework for dealing with the rights of minors to consent to medical treatment. Medical treatment is defined broadly and would cover contraceptive treatment.

(iv) New Zealand

3.114 Section 36 of the *Care of Children Act 2004* states that a consent or refusal to any medical, surgical or dental treatment or procedure, (including blood transfusions) given by a child aged 16 or older has effect as if the child were of full age, where the treatment is carried out for the young person's benefit.¹⁵¹ The common law position does not appear to have been effected by

¹⁴⁷ New South Wales Law Reform Commission *Young People and Consent to Health Care* (Report 119 2008) at 162.

¹⁴⁸ *Ibid* at 163.

¹⁴⁹ *Ibid* at 171.

¹⁵⁰ 4.76.

¹⁵¹ New South Wales Law Reform Commission *Young People and Consent to Health Care* (Report 119 2008) at 125. The *Care of Children Act 2004* replaced the *Guardianship of Infants Act 1968*. Section 25 of the *Guardianship of Infants Act* was similar to section 23 of the *Non-Fatal Offences Against the Person Act 1997*.

the 2004 Act therefore it has been argued that children less than 16 years of age can consent to medical treatment if they are a mature minor¹⁵².

3.115 The 2004 Act does not refer to contraception, but section 38 states that a female of any age can consent to or refuse an abortion, as if she were of full age. In 1990, section 3 of the *Contraception, Sterilisation and Abortion Act 1977*, regulating the provision of contraceptives to young people below 16 years of age, was repealed. There are no age restrictions on the provision of contraceptives in New Zealand, and the common law mature minor rules are followed regarding the prescription of contraception¹⁵³.

(v) Canada

3.116 The mature minor rule has been accepted as part of the common law of Canada, discussed in Chapter 4.¹⁵⁴ In 1975 the issue of the age of consent to medical, surgical and dental treatment was discussed at the Conference of Commissioners on Uniformity of Legislation in Canada. An Act entitled *Medical Consent of Minors* was adopted, which set the age of consent at 16 years, but also made provision for the consent for a mature minor under the age of 16. Medical treatment was defined as including any procedure undertaken for the purpose of preventing pregnancy.

3.117 The Alberta Law Reform Institute published a background paper *Consent of Minors to Medical Treatment* and a report *Consent of Minors to Healthcare* in 1975, recommending that the general age of consent be fixed at 16 years¹⁵⁵. The Law Reform Institute's study of the law in relation to the consent of minors was a response to a request from a Family Planning Conference to investigate the legal pressures limiting the prescribing of contraceptives to young people below the age of 18. The Commission advocated a broad definition of medical treatment which would cover contraception. Furthermore, the Commission recommended that, for certain categories of care, including contraceptive care, there should be no minimum age of consent. This was based on an increase in sexual activity among minors

¹⁵² See chapter 4 at 4.86 for further discussion.

¹⁵³ Thompson "Whose Right to Choose? A Competent Child's Right to Consent to and Refuse Medical Treatment in New Zealand" (2001-2001) 8 *Canterbury Law Review* 145 at 154. Skegg & Paterson *Medical Law in New Zealand* (Thompson Brookers 2006) at 474.

¹⁵⁴ At 4.19.

¹⁵⁵ Institute of Law Research and Reform Alberta *Consent of Minors to Medical Treatment* (Background Paper 9 1975) *Consent of Minors to Healthcare* (Report 19 1975-76).

and the fact that the withholding of contraceptive advice is not a deterrent to such activity. The Commission ruled out the possibility of a doctor being charged with aiding and abetting a criminal offence in relation to the age of consent under the Criminal Code. The Commission also recommended that a minor who has borne a child should be able to consent to health care for herself and her child. There was no formal implementation of the Commission's recommendations however the mature minor rule has been developed by the courts, and modified by child welfare legislation.¹⁵⁶

3.118 In 1978, the Law Reform Commission of Saskatchewan published *Tentative Proposals for a Consent of Minors to Health Care Act*. The Commission acknowledged that there will be situations where young patients below the age of 16 are unwilling, or perhaps unable to obtain parental consent. Presumably the Commission was referring to sensitive issues of sexual and mental health, where confidentiality is particularly important. In such situations, the health and well-being of the patient is paramount and parental consent can be dispensed with if the patient is sufficiently mature to understand the nature and consequences of the health care in question.¹⁵⁷ In relation to patients under the age of 16 who are not sufficiently mature, parental consent must be sought or a court order can be obtained to dispense with the requirement for parental consent¹⁵⁸. In 1980, the Commission published a second report *Proposals for a Consent of Minors to Health Care Act* which did not follow its earlier tentative proposals but instead sought to codify and preserve the common law mature minor rule. Although no formal action was taken on the proposals, the mature minor rule continues to apply in Saskatchewan.

3.119 The Manitoba Law Reform Commission considered the issue of *Minor's Consent to Health Care* in 1995, recommending the preservation of the mature minor rule, in its present form. Echoing other law reform bodies, the Law Reform Commission of Manitoba referred to the importance of unimpeded and confidential access to health care in respect to matters where there may be a reluctance to inform parents, such as sexual health issues and treatment for drug and alcohol abuse. The public interest would be best served by increasing access to health care¹⁵⁹.

¹⁵⁶ See discussion in chapter 4 at 4.36.

¹⁵⁷ Law Reform Commission of Saskatchewan *Tentative Proposals for a Consent of Minors to Health Care Act* (November 1978) at 22.

¹⁵⁸ *Ibid* at 25.

¹⁵⁹ Manitoba Law Reform Commission *Minors Consent to Healthcare* (Report 91 1995) at 31.

3.120 The Civil Code of Quebec¹⁶⁰ creates a distinction between treatment required by the state of health of the minor and treatment that is not required by the state of health of the person, and also distinguishes between minors below and above 14 years of age. A minor who is 14 years or older may consent to care required by his or her state of health. This provision seems to be aimed at facilitating access to mental and sexual health services, such as abortion services, treatment of sexually transmitted diseases, and drug and alcohol abuse. It is likely that contraceptive treatment would be considered as a requirement for the state of the health of a minor, given that a minor can consent to abortion, however this is not explicitly stated in the Code¹⁶¹.

3.121 For treatment that is not required by the minor's state of health, minor's aged 14 years and older may consent themselves unless the treatment in question entails a serious risk to the minor's health. Therefore, regardless of whether or not contraception is considered to be therapeutic and required by the state of health of the minor, a minor aged 14 years or older can consent to non-surgical forms of contraception¹⁶².

(c) Conclusion

3.122 The majority of law reform agencies surveyed in this chapter have addressed the issue of consent to medical treatment by persons under 18 guided by the principle that minors should not be denied access to necessary health care. They have acknowledged the fact that adolescence is a time of rapid development encompassing physical and biological changes. Decisions made during this time can have serious, long lasting effects. Contraception and sexual health in particular, is a matter of concern for public health and the future well-being of young people. To this end, a common thread evident among the research carried out by other law reform bodies is the importance of unimpeded access to contraceptive treatment and advice.

3.123 Furthermore, it is often for the common good of the community that an adolescent receive treatment for particular conditions, such as a sexually transmitted infection, an addiction or a mental health problem¹⁶³. Generally speaking, all of the law reform agencies that have examined the issue of children and medical treatment have agreed on the importance of access to

¹⁶⁰ The Civil Code of Quebec does not recognise the common law mature minor rule.

¹⁶¹ Downie et al *Canadian Health Law and Policy* (3rd ed Lexis Nexis Canada 2007) at 161.

¹⁶² *Ibid* at 164.

¹⁶³ New South Wales Law Reform Commission *Minors Consent to Medical Treatment* (Issues Paper 24 2004) at 67.

certain types of care such as contraception, treatment for addictive behaviour, depression, infections and diseases.

3.124 A Report by the UN Special Rapporteur published in 2009 acknowledged that social preconceptions among adults can present barriers to children's rights to sexual and reproductive health services and information.¹⁶⁴ States however, must ensure that adolescents have access to appropriate health information and services, regardless of parental consent, particularly in relation to sexual and reproductive health. Furthermore, if adolescents are sufficiently mature, they may request confidential services and information.

3.125 Looking at the situation in an Irish context, one must acknowledge that serious decisions regarding alcohol consumption, drug use, sexual initiation and contraception are made by a number of Irish children and young people. The law must acknowledge these decisions and related issues, otherwise significant anomalies are created - such as the teenage mother who can consent to or refuse medical treatment for her child yet cannot make such decisions in relation to her own health care.

3.126 Under section 23 of the *Non-Fatal Offences Against the Person Act 1997*, young people aged 16 years and over can consent to medical treatment. There may be situations where a person below the 16 year old threshold has the capacity to consent to certain types of medical treatment. Furthermore, as mentioned above, certain treatments are often in the interests of public health. These treatments include contraception, treatment for addictions, counselling, and treatment for sexually transmitted diseases and infections. For example, the majority of referrals to Child and Adolescent Mental Health Services are from GPs. This highlights the importance of ensuring that children and young people have access to GPs and are not deterred by issues of consent and confidentiality.

3.127 The Committee on the Rights of the Child has welcomed the introduction in some countries of a fixed age at which the right to consent transfers to the child and has encouraged State parties to give consideration to the introduction of such legislation. The Committee also recommends that where a younger child can demonstrate capacity to express an informed view on his or her treatment, this view should be given due weight.¹⁶⁵

3.128 In line with the General Comments of the Committee on the Rights of the Child, and law reform agencies in other countries, a scheme could be

¹⁶⁴ Resolution adopted by the UN General Assembly "A World Fit for Children" (A/RES/S27-2 2009) at 49.

¹⁶⁵ Committee on the Rights of the Child "*The Rights of the Child to be Heard*" (General Comment No. 12 of 2009 CRC/C/GC/12 1 July 2009) at 102.

implemented to ensure that children and young people can gain access to necessary advice and treatment, whilst retaining the standard threshold of 16 as the age of consent to medical treatment.

3.129 Such an approach would respect the evolving capacity of the child, in line with international and national standards. In its Report on *Vulnerable Adults and the Law*, the Commission stated:

“At the most fundamental level, the Commission does not favour the status approach to capacity because, rather than being capacity and autonomy-building in nature, this approach to capacity is unnecessarily disabling in its effect. Operating at a macro level, the status approach does not take a micro view of the capacity to make decisions in a particular decision-making sphere.”¹⁶⁶

3.130 Young people under the age of 18 make significant decisions on a daily basis in relation to a range of issues encompassing education, employment, the environment, relationships, sexuality, contraception, drugs, alcohol and health care. This is a natural part of growing up, of assuming responsibility and developing necessary life skills. The evolving capacity of an individual must be respected, particularly in the context of health care¹⁶⁷. To this end, the Commission provisionally recommends that, in the context of health care provision, the law should respect the evolving capacity of individuals under the age of 17, with the aim of promoting access to necessary medical treatment. The details of this scheme are outlined and discussed in Chapter 4.¹⁶⁸

3.131 *The Commission provisionally recommends that, in the context of health care provision, the law should respect the evolving capacity of individuals under the age of 17, with the aim of promoting access to necessary medical treatment.*

¹⁶⁶ Law Reform Commission *Vulnerable Adults and the Law* (LRC 83-2006) at 2.25.

¹⁶⁷ See discussion at 2.06.

¹⁶⁸ 4.112.

CHAPTER 4 CAPACITY TO CONSENT TO MEDICAL TREATMENT IN IRELAND

A Introduction

4.01 This chapter outlines the current legal situation in relation to children and consent to medical treatment. Part B examines the relevant issues under Irish law, while Part C looks at the position in other jurisdictions. Part D contains a discussion of the main points raised and Part E concludes with the Commission's provisional recommendations.

B Age of Consent to Medical Treatment in Ireland

4.02 In respect of the age of consent to medical treatment in Irish law, there is no equivalent of the mature minor rule or case law along the lines of the English or Canadian jurisprudence discussed in Chapter 3.¹ In context of criminal law, however, section 23(1) of the *Non-Fatal Offences Against the Person Act 1997* provides:

“The consent of a minor who has attained the age of 16 years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his or her person, shall be as effective as it would be if he or she were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his or her parent or guardian”

4.03 The 1997 Act is clearly a criminal statute and it is unclear whether section 23 is applicable outside the context of a defence to, for example, a charge of assault under the 1997 Act. Most commentators treat section 23 of the 1997 Act as one of general application, as the wording of the section is based on virtually identical wording found in section 8 of the English *Family Law Reform Act 1969*.² In the Commission's view, however, section 23 does not

¹ *Gillick v West Norfolk and Wisbech Health Authority* [1985] 3 All ER402. See discussion at 3.83.

² See discussion of Section 8 of the *Family Law Reform Act 1969* at 4.55.

serve as an explicit acknowledgement of the right of a child to participate in decisions regarding his or her medical treatment.³

4.04 Legislatively, it would appear that while children have no automatic right to express their views regarding their medical treatment, those aged 16 have the authority to consent, and possibly to refuse medical treatment.

4.05 Section 23 of the 1997 Act does not expressly prohibit children less than 16 years of age from consenting to treatment and it is therefore unclear whether the section is facilitative (automatic consent granted to children aged 16, whilst children under 16 are not prevented from giving valid consent) or preventative (preventing all children under 16 from giving valid consent).⁴ McMahon and Binchy⁵ have stated that if section 23(1) was viewed in isolation, the *inclusio unius est exclusio alterius* rule of construction might indicate that 16 should be the minimum age for lawful consent by a minor.⁶ However section 23(3) states:

“Nothing in this section shall be construed as making ineffective any consent which would have been effective if this section had not been enacted.”

³ See generally, Madden *Medicine, Ethics and the Law* (Butterworths 2002) at 490 Kilkelly *Children’s Rights in Ireland* (Tottel Publishing 2008) at 440, Feldman “The Constitution, The Child and Health: Ignoring the Elephant in the Room” in Doyle and Carolan (eds) *The Irish Constitution: Governance and Values* (Thompson Round Hall 2008).

⁴ Donnelly *Consent: Bridging the gap between doctor and patient* (Cork University Press 2002) at 48.

⁵ Mc Mahon and Binchy *Law of Torts* (3rd ed Butterworths 2000) at 640.

⁶ *Inclusio unius est exclusio alterius* or *Expression unius personae vel rei, est exclusio alterius* (“to express one thing is to exclude another”) is a maxim which allows the courts to imply that where an Act applies a rule to a particular situation, the Oireachtas intended to confine the rule to that situation, and not to apply it in any wider context. The maxim is subject to limitations and does not apply where a legislative provision merely states a particular aspect or particular application of a more general rule of law. See Law Reform Commission *Consultation Paper on Statutory Drafting and Interpretation: Plain Language and the Law* (CP 14-1999) at 1.071. Applying the maxim to section 23(1) one could assume that since the provision refers specifically to people over 16 years of age, people under that age are excluded, and therefore cannot legally consent to medical treatment. The impact of section 23(3) however raises doubts as to the applicability of the maxim in this instance.

4.06 This suggests that the Oireachtas left open the question of whether a minor under the age of 16 has the capacity to consent to medical treatment. A similar suggestion was discussed and accepted by the House of Lords in the *Gillick* case, regarding what appears to be the statutory analogue for section 23, section 8 of the *Family Law Reform Act 1969*, discussed below.⁷ In New Zealand, Section 25 of the *Guardianship Act 1968*, replaced by Section 36 of the *Care of Children Act 2004* contains an identical provision⁸. The Canadian province of British Columbia enacted the *Infants Act* in 1973, again very similar to section 8 of the *Family Law Reform Act 1969*, including a saver to accommodate the consent of young people under 16 years of age⁹. These ‘saver’ provisions have been viewed as a safeguard to preserve the existing common law on capacity. The Law Reform Commission, commenting on section 8 of the *Family Law Reform Act 1969* in its 1994 *Report on Non-Fatal Offences Against the Person*, stated that:

“The enactment of such a provision in Irish law would provide for an element of certainty. It would, of necessity, have to accommodate the case of legitimate consents by persons under 16 years of age, or any other specified age, by the inclusion of a saver similar to subs.(3)”¹⁰

4.07 One can assume therefore, that the Irish courts would recognise section 23(3) as a saver, intended to incorporate and preserve the common law on capacity.

4.08 Regardless of this assumption, it is evident that clarity is needed. The ambiguous state of the legal capacity of children and young people to consent to medical treatment creates significant problems, as the medical profession is left to operate in something of a legal limbo. Without any clear or explicit explanation of the law, medical and health care professionals have followed a cautious approach and have been advised to obtain the consent of parents or guardians when treating children and young people, if possible. Thus, one commentator has called for the introduction of legislation which would clarify the basis on which doctors may provide treatment to 13, 14 and 15 year olds. The

⁷ 4.57.

⁸ 4.87.

⁹ See 4.30.

¹⁰ Law Reform Commission *Report on Non-Fatal Offences Against the Person* (LRC 45-1994) at 9.168.

writer argues that GP's are currently working in a legal vacuum, frequently dealing with under 16s in the absence of parental consent.¹¹

4.09 The Health Service Executive published guidelines entitled "Staff Guidelines for Obtaining Consent for Non Emergency Treatment/Services from Parents of Children and Young People under 18 Years of Age".¹² The document contains three guiding principles, namely – the welfare of the child is paramount, working in partnership with parents is beneficial for children, and the views of children must be taken into consideration, in accordance with their age and level of maturity and understanding. Moving on from the guiding principles, there is little or no reference to the right of a child or young person, of any age, to consent to medical treatment. The document seems to be aimed at clarifying the legal situation in relation to consent where there are one or more guardians, as opposed to setting out the rights of a young person to make health care decisions.

4.10 In 2004 the Medical Council briefly addressed the issue of children and consent, stating that:

"If the doctor feels that a child will understand a proposed medical procedure, information or advice, this should be explained fully to the child. Where the consent of parents or guardians is normally required in respect of a child for whom they are responsible, due regard must be had to the wishes of the child. The doctor must never assume that it is safe to ignore the parental/guardian interest."¹³

4.11 The advice reflects the importance of ensuring that all patients are informed, regardless of age, yet there remains an explicit deference to parental consent. Also, the separate issues of information provision and consent to medical treatment are somewhat mixed together. There is no duty placed on doctors and health care professionals to listen to the views of a young patient, regardless of the fact that children are placed in adult wards in hospitals before the age of 16 or 18, adapting to a routine of hospitals, doctors, treatment and medication. As discussed earlier, children may not have the capacity to consent to medical treatment however they have a right to be informed and express their opinions.¹⁴ Section 23 of the *Non-Fatal Offences Against the Person Act 1997* does not feature in the guidance issued by the Medical Council.

¹¹ Dr Simon Mills "Mature Minors Should be Allowed to Consent to Treatment" Irish Medical News 23 Oct 2009.

¹² <http://www.hse.ie/eng/Publications/services/Children/medconsentpub.html>

¹³ Medical Council *A Guide to Ethical Conduct and Behaviour* (6th ed 2004) at 32.

¹⁴ See discussion at 1.39.

4.12 The more recent guidance issued by the Medical Council in 2009 is appreciated as it contains a more detailed reference to children and their capacity to consent to medical treatment. The guidance states that children and young people should be involved as much as possible in discussions about their health care.

“When you are talking to a child or young person, it is important to give them information in an age appropriate manner, listen to their views and treat them with respect”¹⁵

4.13 Referring to section 23 of the 1997 Act, the guidance states that persons aged 16 years and over are entitled by law to give their own consent to medical, surgical and dental treatment. In relation to persons under the age of 16, the guidance states:

“In exceptional circumstances, a patient under 16 might seek to make a healthcare decision on their own without the knowledge or consent of their parents. In such cases you should encourage the patient to involve their parents in the decision, bearing in mind your paramount responsibility to act in the patient’s best interests.”¹⁶

4.14 This statement by the Medical Council acknowledges the fact that a number of young people under the age of 16 are actively involved in health care planning and decision making. It is important that the guidance specifically refers to the best interests of the patient, which are separate from the wishes of parents or guardians.

4.15 Research has shown how experience of illness enables children to develop the understanding and maturity to take responsibility for their health and make health care decisions. On a practical level, studies have shown that increased participation and patient choice can lead to improved treatment outcomes.¹⁷ Children are capable of reaching decisions and articulating their wishes regarding medical care, when given the opportunity.

4.16 As stated above, the ambiguous state of the legal capacity of children to consent to medical treatment creates a host of problems, as the medical profession is left to operate in a legal limbo, particularly regarding contentious issues such as contraception and drug treatment. The confusing nature of the present legal situation is brought sharply into focus when one considers the

¹⁵ Medical Council *A Guide to Ethical Conduct and Behaviour* (7th ed 2009) at 40.

¹⁶ *Ibid* at 41.

¹⁷ Madden *Medicine, Ethics and the Law* (Butterworths 2002) at 474.

anomaly created by the minor who is a parent.¹⁸ The young mother can consent to medical treatment on behalf of her child, yet her legal capacity to make decisions regarding her own medical treatment is not clear. Various commentators have referred to this anomaly, with one giving the example of a 14 year old mother who can consent to a vaccination for her child, yet cannot consent to her own medical treatment.¹⁹

4.17 The guidelines issued by the Health Service Executive do not shed any light on the matter. The guidelines state that the legal situation of the young mother is unclear because minors are deemed to be legally incompetent to give consent. There is no reference to section 23 of the *Non-Fatal Offences Against the Person Act 1997* or the common law. The Commission assumes that the minor referred to in the guidelines is below the age of 16, but this is not clear. The guidelines also state that leeway is given to the unmarried minor mother of a child, because she is the sole legal guardian of the child. There is no explanation of what exactly 'leeway' entails in the context of consent to medical treatment. Moreover, it is recommended, as prudent practice, to obtain the consent of an appropriate next of kin. There is no elaboration as to who would be the appropriate next of kin. Perhaps the Health Service Executive presumes the grandparent of the child would be appropriate. The legality of this is questionable however as the relationship between grandparent and grandchild is not constitutionally protected, save where the grandparent is also a guardian of the child²⁰. In cases of doubt or uncertainty, it is recommended that health care providers seek further legal advice. It seems highly unpractical, and burdensome, for health care providers to obtain the consent of a child's grandparent, and possibly seek legal advice, before they can treat the child in question.

4.18 In relation to children and young people in Emergency Care, Interim Care, or Voluntary Care, consent for medical treatment must be obtained from their legal guardian. Although the Health Service Executive can consent to medical treatment for children and young people in care under a full care order, best practice is to obtain consent from the legal guardian. Under sections 13(7), 17(4) and 47 of the *Child Care Act 1991* the Health Service Executive can apply for direction in relation to medical treatment and obtain a court order to

¹⁸ Feldman "The Constitution, the Child and Health: Ignoring the Elephant in the Room" in Doyle & Carolan (eds) *The Irish Constitution: Governance and Values* (Thompson Round Hall 2008) at 396.

¹⁹ Dr Simon Mills Irish Medical News "Mature Minors should be allowed to consent to treatment" 23 Oct 2009.

²⁰ Fitzpatrick "Time for Answers: The Lingering Uncertainty for Mothers Under the Age of Sixteen" (2004) 4 *University College Dublin Law Review* 117 at 125.

dispense of the requirement for consent if the parent or guardian is absent or will not give consent. This situation leads to practical problems and delay in obtaining consent for necessary medical treatment, particularly in situations where the child or young person in question does not have a good relationship with his or her parents or guardian, or in situations where the parent or guardian is hostile and uncooperative.

C Age of Consent to Medical Treatment in other Jurisdictions

(1) Canada

4.19 It is important to examine how other countries have addressed the issue of consent to medical treatment by persons under 18, primarily by developing the mature minor rule. The mature minor rule is well established in Canada, and some of the different legal provinces and territories have also passed legislation on the subject.²¹ In 1975 the issue of the age of consent to medical, surgical and dental treatment was discussed at the Conference of Commissioners on Uniformity of Legislation in Canada. An Act entitled *Medical Consent of Minors* was adopted, which set the age of consent at 16 years, but also made provision for the consent for a mature minor under the age of 16. The Act was adopted in New Brunswick only.

4.20 Several of the law reform bodies in Canada have examined the issue of minors consent to medical treatment. The age of consent to medical treatment is regulated in different statutory forms by the provinces and territories of Canada, in tandem with the mature minor rule. Health care consent legislation has greatly influenced the application of and adherence to the mature minor rule. The approach taken by the legislature in British Columbia and New Brunswick is focused on the best interests of a mature minor and whether or not the health care decision is in the minor's best interests, as determined by the courts. In Ontario and Prince Edward Island, however, the statutory focus is solely on the minor's capacity to make medical decisions and entitles capable minors of any age to make health care decisions.²²

4.21 The provinces that do not have specific legislation addressing the legal capacity of minors to make health care decisions are reliant on the mature

²¹ See Day "The Capable Minor's Healthcare: Who Decides?" (2007) 86 (3) *The Canadian Bar Review* 379, Ferguson *The End of An Age: Beyond Age Restrictions for Minors Medical Treatment Decisions* (Paper prepared for the Law Reform Commission of Canada 2004).

²² Ferguson *The end of An Age: Beyond Age Restrictions for Minors Medical Treatment Decisions* (Paper prepared for the Law Reform Commission of Canada 2004) at 8.

minor rule, supplemented by child welfare legislation. The potential for child welfare legislation to override decisions made by a mature minor has arisen, primarily in the context of refusal of medical treatment.²³ These developments are discussed further in chapter 5.²⁴

4.22 It is clear that the mature minor rule has been utilised for some time in Canada. In 1910, an Ontario court held that the consent of a 19 year old boy to a surgical procedure was valid, despite the fact that he was below 21 years of age, the age of majority.²⁵ His parents had not been consulted, however the court held that the 19 year old was capable of taking care of himself and his consent was a defence to charges of trespass or assault. This case was largely concerned with the application of the common law “emancipated minor” rule, which grants minors who are independent and emancipated from parental control, legal rights, including the right to consent to medical treatment.

4.23 In 1971, several years before the *Gillick*²⁶ case, the High Court of Ontario held that a minor who was capable of understanding the possible consequences of a medical procedure was capable of giving a valid consent to the procedure.²⁷ Addy J stated:

“I can find nothing in any of the old reported cases, except where infants of tender age or young children were involved, where the Courts have found that a person under 21 years of age was legally incapable of consenting to medical treatment”²⁸

4.24 In 2009, in *A.C. v Manitoba (Director of Child and Family Services)*²⁹ the Supreme Court of Canada analysed the existing jurisprudence on the mature minor rule and the legal capacity of competent minors to make health care decisions. The case concerned the refusal of medical treatment by a 14 year old mature minor and is discussed briefly in the following paragraphs, with a more detailed discussion in chapter 5.³⁰

²³ *Ibid* at 15.

²⁴ 5.24.

²⁵ *Booth v Toronto General Hospital* (1910) 17 O.W.R. 118 (Ont. K.B.)

²⁶ *Gillick v West Norfolk and Wisbech Health Authority* [1985] 3 All ER402.

²⁷ *Johnston v Wellesley Hospital* (1971), 2 O.R. 103 at (Ont H Ct).

²⁸ Addy J at 109.

²⁹ 2009 SCC 30.

³⁰ 5.51.

4.25 Arbella J described the mature minor rule as a recognition by the common law that children are entitled to a degree of decision-making autonomy that is reflective of their evolving intelligence and understanding. The evolutionary and contextual character of maturity makes it difficult to define and evaluate, yet the right of mature adolescents to have their medical decision making ability respected means that an assessment of maturity must be undertaken with respect and rigour. A number of factors were outlined which may assist courts in an evaluation of maturity:

- 1) What is the nature, purpose and utility of the recommended medical treatment? What are the risks and benefits?
- 2) Does the adolescent demonstrate the intellectual capacity and sophistication to understand the information relevant to making the decision and to appreciate the potential consequences?
- 3) Is there reason to believe that the adolescent's views are stable and a true reflection of his or her core values and beliefs?
- 4) What is the potential impact of the adolescent's lifestyle, family relationships and broader social affiliations on his or her ability to exercise independent judgement?
- 5) Are there any existing emotional or psychiatric vulnerabilities?
- 6) Does the adolescent's illness or condition have an impact on his or her decision-making ability?
- 7) Is there any relevant information from adults who know the adolescent, like teachers or doctors?³¹

4.26 The Commission considers that these factors underline that the assessment of the concept of a mature minor is not limited to the factors set out, for example, by Lord Fraser in the *Gillick* case, which the Commission discusses below.³² They indicate that the 'Fraser Guidelines' are not, and never purported to be, rigid statutory formulae that must be applied across the board in this complex matter.

4.27 The Commission now turns to examine the operation of the mature minor rule in a number of Canadian states and territories.

³¹ Arbella J at 96.

³² 4.52.

(i) New Brunswick

As mentioned above, New Brunswick adopted the act recommended by the Uniform Law Conference in 1975.³³ The *Medical Consent of Minors Act* 1976 grants people aged 16 years and older the right to consent to medical treatment as if they were of full age:

“The law respecting consent to medical treatment of persons who have attained the age of majority applies, in all respects, to minors who have attained the age of sixteen years in the same manner as if they had attained the age of majority.”

4.28 The consent of a person below 16 years of age may be as effective as if that person had reached the age of majority if, in the opinion of a health care practitioner, the person is capable of understanding the nature and consequences of the treatment, and the treatment is in the best interests of the young person and his or her health and well-being.³⁴

4.29 In 1994, the New Brunswick Court of Appeal stated, that in Canada, the common law recognises the doctrine of a mature minor, namely, one who is capable of understanding the nature and consequences of the proposed treatment.³⁵ Accordingly, a minor, if mature, has the legal capacity to consent to his or her own medical treatment. Hoyt CJ stated that the 1976 Act had codified the common law, and also held that the courts *parens patriae* jurisdiction ends when a mature minor is capable of making medical decisions.³⁶ This view was not supported by Ryan and Angers JJ however, who agreed that the court’s *parens patriae* jurisdiction persists despite the provisions of the *Medical Consent of Minors Act* and the mature minor rule.

(ii) British Columbia

4.30 In 1973, legislation was passed which established a framework for minors to consent to medical treatment. Section 8 of the English *Family Law Reform Act 1969* is seen as a predecessor to section 16 of the British Columbia *Infants Act 1973*, and of course section 23 of the *Non-Fatal Offences Against*

³³ With the amendment that medical treatment did not include a procedure undertaken for the purpose of preventing pregnancy.

³⁴ *Medical Consent of Minors Act*, SNB 1976, c.M-6.1 (New Brunswick) s.3(1).

³⁵ *Region 2 Hospital Corp v Walker* [1994] NBJ 174 (NBQB) rev’d [1994] NBJ 242 (NBCA).

³⁶ Hoyt CJ at 29. See Garner (ed) *Black’s Law Dictionary* (7th ed West Group 1999) *Parens Patriae* “The state regarded as sovereign; the state in its capacity as provider of protection to those unable to care for themselves”

the Person Act 1997. In its original form, section 16 of the *Infants Act* stated that a sixteen year old could consent to surgical, medical, mental or dental treatment, as if he or she were of full age. For the consent to be effective however, reasonable efforts must have been made to gain parental consent, and the treating practitioner must have secured a second opinion that the treatment was in the best interests of the patient. The development of the mature minor rule greatly reduced the applicability and relevance of section 16, as the common law became more liberal than the 1973 legislation.³⁷

4.31 *The Infants Act* was amended in 1992, to codify the common law and did not retain the age of 16 as the age of consent to medical treatment.³⁸ Section 17 of the Act states:

“(2) Subject to subsection (3), an infant may consent to health care whether or not the health care would, in the absence of consent, constitute a trespass to the infant’s person, and where an infant provides that consent, the consent is effective and it is not necessary to obtain a consent to the health care from the infant’s parent or guardian.

(3) No request for or consent, agreement or acquiescence to health care by an infant shall constitute consent to the health care for the purposes of subsection (2) unless the health care provider providing the health care

(a) has explained to the infant and has been satisfied that the infant understands the nature and consequences and reasonably foreseeable benefits and risks of the health care and,

(b) has made reasonable efforts to determine and has concluded that the health care is in the infant’s best interests”

4.32 The provision survived a constitutional challenge in the case of *Ney v Canada (Attorney General) 1993*.³⁹ The British Columbia Supreme Court held that the section simply codified and affirmed the existing common law. Huddart J summarised the common law position with the statement that:

³⁷ See analysis in Manitoba Law Reform Commission *Minors’ Consent to Health Care* (Report 91,1995) at 16-17.

³⁸ Section 16 of the *Infants Act 1973* was amended by Section 16 of the *Infants Act 1992* and renumbered as Section 17 in the *Infants Act 1996* as part of the Statute Law Revision process in British Columbia.

³⁹ *Ney v Canada (Attorney General) 1993* 102 D.L.R. (4th) 136 (BCSC) .

“In sum, where a child has sufficient intelligence and understanding of the nature of the proposed health care he or she is capable at common law to consent to such treatment. If a child does not meet this test, and as a result is incapable of consenting, the consent of the parents of that child will be required.”⁴⁰

4.33 Ferguson has suggested that section 17 may be seen as supplanting the common law mature minor rule, as the best interests requirement in section 17 (3)(b) arguably goes further than the common law test of capacity. In *Ney*, Huddart J briefly referred to the best interests requirement, stating that the provision was designed to reduce the risk of a civil action against the health care practitioner.⁴¹

4.34 In 1999 the British Columbia Court of Appeal considered the mature minor rule in *Van Mol (Guardian ad Litem of) v. Ashmore 1999*.⁴² The appellant was a 15 year old girl who claimed that the treating physician was negligent in failing to inform her of the risks involved in a surgical procedure, and in failing to permit her to participate in the treatment decision. The Court held by failing to inform the patient adequately, the physicians had failed to reach the standard of informed consent. The minor in question was entitled to be treated in the same way that any person of full age and capacity should be treated.⁴³

4.35 Lambert J stated that once the required capacity to consent has been achieved by a young person reaching sufficient maturity, intelligence and capability of understanding, the discussions about the nature of the treatment, its gravity, the risks and the decisions about undergoing the treatment must all take place with and by made by the young person whose bodily integrity is to be invaded and whose life and health will be effected by the outcome.⁴⁴

(iii) Alberta

4.36 The Alberta Law Reform Institute published a background paper *Consent of Minors to Medical Treatment* and a report *Consent of Minors to Healthcare* in 1975.⁴⁵ The Commission alluded to doubts over the equation of

⁴⁰ Huddart J at 141.

⁴¹ Huddart J at 142.

⁴² BCJ No 31 (BCCA).

⁴³ Lambert J at para 112.

⁴⁴ Lambert J at para 75.

⁴⁵ Institute of Law Research and Reform Alberta *Consent of Minors to Medical Treatment* (Background Paper 9 1975) *Consent of Minors to Healthcare* (Report 19 1975-76).

the age of majority to the age of consent to medical treatment, and referred to the unrealistic situation of independent teenagers who still need parental consent from their parents in cases of medical treatment.⁴⁶ All of the submissions received by the Commission stated that there are situations where a minor should be able to consent to treatment.⁴⁷ The Commission recommended that the general age of consent be fixed at 16 years, and in relation to certain categories of care, there should be no minimum age of consent⁴⁸. The Commission also recommended that a minor who has borne a child should be able to consent to health care for herself and her child. There was no formal implementation of the Commission's recommendations however the mature minor rule has been developed by the courts. Recent developments regarding the role of the mature minor rule in the context of refusal of medical treatment are discussed in detail in chapter 5.⁴⁹

4.37 The mature minor rule was applied by the Alberta Court of Appeal in the case of *J.S.C. v Wren 1986*.⁵⁰ The Court held that a 16 year old girl, who had sufficient intelligence and understanding of the consequences of her decision, had the capacity to consent to medical treatment.

4.38 In *B.H. v Alberta 2002*, Kent J discussed the mature minor principle, stating that mature minors are capable of making all manner of medical decisions.⁵¹ The common law has recognised that there comes a time in the maturation process where teenagers should have more and more say over their bodies.⁵² He also stated that “what mature minor status requires is the

⁴⁶ Institute of Law Research and Reform Alberta *Consent of Minors to Medical Treatment* (Background Paper 9 1975) at 2.

⁴⁷ Institute of Law Research and Reform Alberta *Consent of Minors to Healthcare* (Report 19 1975/6) at 9.

⁴⁸ “A minor of any age may consent to health care in connection with any communicable disease as defined in the *Public Health Act*, drug or alcohol abuse, prevention of pregnancy and pregnancy and its termination.” Institute of Law Research and Reform Alberta *Consent of Minors to Healthcare* (Report 19 1975/6) at 62.

⁴⁹ 5.38.

⁵⁰ *JSC and CHC v Wren (1986)* 76 AR 118 (Alta QB) aff'd (1987) 76 AR 115 (Alta CA).

⁵¹ *B.H. (Next friend of) v. Alberta (Director of Child Welfare)* [2002] A.J. No.518 (Alta. QB).

⁵² Kent J at para 30.

intelligence to do the analysis, not that it has been done".⁵³ One commentator has interpreted this as a suggestion that the Canadian approach favours a different approach to that of the English mature minor rule.⁵⁴ In Canada, it is enough for a minor to be a capable decision maker, regardless of whether or not the minor analysed the decision in a particular way.⁵⁵

(iv) Saskatchewan

4.39 In 1978, the Law Reform Commission of Saskatchewan published *Tentative Proposals for A Consent of Minors to Health Care Act*.⁵⁶ The Commission stated that modern teenagers have a very different lifestyle to their counterparts of earlier generations and the concept of parental authority had changed. The Commission recommended that teenagers aged 16 years of age and older should be capable at law of consenting to their own health care. This recommendation was based on the fact that the age of 16 was seen as a legislative foundation for other activities such as driving, receiving social assistance and ending full time education. The Commission also endorsed the mature minor rule and acknowledged that there will be situations where young patients below the age of 16 are unwilling, or perhaps unable to obtain parental consent. In such situations, the health and well-being of the patient is paramount and parental consent can be dispensed with if the patient is sufficiently mature to understand the nature and consequences of the health care in question. In relation to patients under the age of 16 who are not sufficiently mature, parental consent must be sought or a court order can be obtained to dispense with the requirement for parental consent.⁵⁷ In 1980, the Commission published a second report *Proposals for a Consent of Minors to Health Care Act* which did not follow its earlier tentative proposals but instead sought to codify and preserve the common law mature minor rule. Although no formal action was taken on the proposals, the mature minor rule remains in force in Saskatchewan.⁵⁸

⁵³ Kent J at para 36.

⁵⁴ Ferguson *The end of An Age: Beyond Age Restrictions for Minors Medical Treatment Decisions* (Paper prepared for the Law Reform Commission of Canada 2004) at 12.

⁵⁵ *Ibid.*

⁵⁶ Law Reform Commission of Saskatchewan *Tentative Proposals for a Consent of Minors to Health Care Act* (November 1978) at 22.

⁵⁷ *Ibid* at 25.

⁵⁸ Saskatchewan has recognised the capacity of a 16 year old to make an advance care directive. See 5.162.

(v) Manitoba

4.40 A legislative policy has developed in Manitoba, rejecting a fixed rule for medical consent in favour of an individualised assessment of capacity.⁵⁹

4.41 The Manitoba Law Reform Commission published a report in 1995 with a recommendation that the common law concept of maturity should be maintained to determine whether or not a young person has the power to make health care decisions.⁶⁰ The Commission did not believe that the mature minor rule should be put in legislative form due to a danger of anchoring the law into inflexible legislative language which may be insensitive to a variety of unforeseen and future changes in society and medical practice.

“The different pace of a child’s development, the vast array of medical procedures of varying seriousness and significance and the differences in family relationships and socio-economic circumstances of children all support a process of individualized assessment.”⁶¹

4.42 A report published by the Manitoba Law Reform Commission in 2004, entitled *Substitute Consent to Health Care*, briefly addressed the issue, stating that when considering a minor’s maturity, a court will consider the physical, emotional and intellectual maturity of the child, the nature of the parent-child relationship, the lifestyle of the minor and the nature of the medical condition for which the treatment is being sought.⁶²

4.43 In the 2007 case of *Director of Child and Family Services v A.C.2007*⁶³ the Manitoba Court of Appeal confirmed that at common law, mature minors, similar to adults, have the capacity to decide their own medical care. The case, referred to above at 4.24 is discussed further in chapter 5 in relation to refusal of medical treatment.

(vi) Ontario

4.44 Section 2(2) of the *Substitute Decisions Act 1992* establishes a presumption that people aged 16 years and over are capable of giving or

⁵⁹ Day “The Capable Minor’s Healthcare: Who Decides?” (2007) 86(3) *Canadian Bar Review* 279 at 386.

⁶⁰ Manitoba Law Reform Commission *Minors’ Consent to Health Care* (Report 91 1995) at 33.

⁶¹ *Ibid.*

⁶² Manitoba Law Reform Commission *Substitute Consent to Health Care* (Report 110 2004) at 8.

⁶³ MBCA 9.

refusing consent in respect of their own personal care⁶⁴. *The Consent to Treatment Act 1992*, replaced by the *Health Care Consent Act 1996*, was enacted to codify the law relating to consent to medical treatment and established rules and procedures for administering health care to incapable persons. Section 4(1) of the 1996 Act states:

“A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision”

4.45 Thus, a mature minor has a statutory right to consent to treatment, regardless of whether the health care provider considers the treatment to be in his or her best interests. The word “appreciate” in this context means an ability to evaluate the information as well as understanding it.⁶⁵ The evaluation of capacity will be made by the health care practitioner applying prescribed standards and procedures to the patient. There is also a method of review available whereby those deemed incapable can apply to the Consent and Capacity Board for a review of the assessment, with the option of a final appeal to the courts.

(vii) Prince Edward Island

4.46 The statutory position in Prince Edward Island is similar to that of Ontario, in that the focus of the legislation is on capacity to make a medical decision and there is no age based presumption of capacity.

4.47 *The Consent to Treatment and Health Care Directives Act 1988* states that:

“Every patient who is capable of giving or refusing consent to treatment has the right

- (a) to give consent or to refuse consent on any grounds, including moral or religious grounds, even if the refusal will result in death;
- (b) to select a particular form of treatment from among those proposed by a health practitioner on any grounds, including moral or religious grounds;
- (c) to be assisted by an associate; and

⁶⁴ Section 2(2) “ A person who is 16 years of age or more is presumed to be capable of giving or refusing consent in connection with his or her own personal care”.

⁶⁵ *Starson v Swayze* [2003] 1 SCR 32 at para 17

(d) to be involved to the greatest degree practicable in case planning and decision making.”

4.48 Capacity is assessed by a health care practitioner according to the patient’s ability to understand the information that is relevant to making a decision concerning the treatment, to understand the information that applies to his or her particular situation, to understand his or her right to make a decision; and appreciate the reasonably foreseeable consequences of a decision or lack of decision.⁶⁶

(viii) Quebec

4.49 It is interesting to compare the regulation of minors consent to medical treatment in Quebec with that of the other Canadian provinces, as there is no civil law equivalent to the mature minor rule.

4.50 In Quebec the provisions governing the consent of minors are found in articles 14-18 of the Civil Code. A minor aged 14 years of age may consent to care required by his or her state of health. If the treatment requires the minor to be hospitalized for over 12 hours, the person with parental authority or the tutor shall be informed of the hospital stay, without any further information being revealed. It seems that the aim of this provision is to facilitate access to confidential medical care for adolescents in relation to sexual and mental health concerns.

4.51 Article 17 states that a minor aged 14 years of age may consent alone to care not required by the state of his or her health, with the condition that parental consent is required if the care entails a serious risk for the health of the minor and may cause him or her serious effects.

(2) England

4.52 As discussed in Chapter 3, the decision of the House of Lords in *Gillick v West Norfolk and Wisbech Health Authority 1985*⁶⁷ influenced the development of the mature minor rule which is widely accepted in Scotland, Australia, New Zealand, Canada and the United States.

4.53 Issues in relation to the capacity and maturity of minors in England had been addressed by the courts before the *Gillick* case. One of the key issues in the case of *Hewer v Bryant 1969* was whether or not a 15 year old boy was,

⁶⁶ Consent to Treatment and Health Care Directives Act 1988 RSPEI 1988, c. C-17.2 s.7(1).

⁶⁷ 3 All ER402.

by virtue of his age, deemed to be in the custody of his parents.⁶⁸ Lord Denning rejected the notion that an infant is, by law, in the custody of his father until he is 21.⁶⁹

“I decline to accept a view so much out of date. The common law can, and should keep pace with the times. It should declare..... that the legal right of a parent to the custody of a child ends at the eighteenth birthday; and even up till then, it is a dwindling right which the courts will hesitate to enforce against the wishes of the child, the older he is. It starts with a right of control and ends with little more than advice.”⁷⁰

4.54 Lord Denning’s judgment was relied on as precedent in *Gillick*, to illustrate that common law had recognised that a minor can achieve an age of discretion before reaching the age of majority.

4.55 One of the core issues of the *Gillick* case concerned section 8(1) of the *Family Law Reform Act 1969* which states:

“The consent of a minor who has attained the age of sixteen to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his person, shall be as effective as it would be if he were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian”

4.56 Mrs Gillick contended that if section 8 had not been enacted, a minor’s consent to medical treatment would not be effective. This argument was not accepted. The majority of the Law Lords held that the effect of section 8 was to clarify the existing law and remove any doubt in relation to the consent of minors aged 16 years old. It is interesting to note the treatment of section 8 by the House of Lords, particularly the saver in 8(3), which is identical to the saver in section 23(3) of the *Non-Fatal Offences Against the Person Act 1997*, referred to above.⁷¹ In its 1994 *Report on Non-Fatal Offences Against the Person*, which the 1997 Act implemented, the Commission recommended the introduction of legislation similar to section 8 of the *Family Law Reform Act*

⁶⁸ 3 All ER 578.

⁶⁹ Referring to the case of *Re Agar Ellis* 1883 24 Ch.D. 317 which held that a father has control over the person, education and conduct of his children until they are 21.

⁷⁰ Lord Denning at 582.

⁷¹ 4.05.

1969 providing for the consent to medical treatment of persons who have attained the age of 16 and including a 'saver' to accommodate legitimate consents by persons under 16 years of age.⁷²

4.57 Section 8(3) of the English 1969 Act, and section 23(3) of the 1997 Act both state:

"Nothing in this section shall be construed as making ineffective any consent which would have been effective if this section had not been enacted."

4.58 In the *Gillick* case, the majority of the House of Lords concluded that the saver in section 8(3) essentially left open the question as to whether the consent of a minor aged below 16 could be an effective consent. Ultimately the House of Lords answered the question in the affirmative. Lord Fraser found:

"no statutory provision which compels me to hold that a girl under the age of 16 lacks the legal capacity to consent to contraceptive advice, examination and treatment provided she has sufficient understanding and intelligence to know what they involve."

4.59 Lord Scarman, concurring with Lord Fraser, stated that section 8 clarified the law without conveying any indication as to what the law was before it was enacted. In relation to minors under the age of 16, the law remained the same as it was before the enactment of section 8. In his analysis of the common law, Lord Scarman referred to cases involving the "age of discretion", showing that a minor can in law achieve an age of discretion before coming of full age.⁷³ A child under the age of 16 does not lack capacity by virtue of age alone, and his or her capacity should not be determined by reference to a judicially fixed age limit. Lord Fraser stated that it would be absurd to suggest that a girl or a boy aged 15 could not effectively consent, for example, to have a medical examination of some trivial injury to his body or even to have a broken arm set. Furthermore:

"It is in my view, contrary to the ordinary experience of mankind...to say that a child or a young person remains in fact under the complete control of his parents until he attains the definite age of majority, now 18 in the United Kingdom, and that on attaining that age he suddenly acquires independence."⁷⁴

⁷² Law Reform Commission *Report on Non-Fatal Offences Against the Person* (LRC 45-1994) at 9.165.

⁷³ Lord Scarman at 422.

⁷⁴ Lord Fraser at 411.

4.60 Parental rights clearly exist, but the common law has never treated such rights as sovereign or beyond review and control. Lord Scarman stated:

“parental rights are derived from parental duty and exist only so long as they are needed for the protection of the person and property of the child”⁷⁵

4.61 In essence, the majority stated that parental rights are limited and recede as the child matures, and a strict age rule fails to take account of the growing maturity of the child.

4.62 The majority judgements in *Gillick* stressed that the relevant factor in the assessment of an individual’s autonomy was not the age of the individual but his or her ability to understand fully what was proposed. A child, according to Lord Scarman:

“acquires capacity when he reaches a sufficient understanding and intelligence to be capable of making up his own mind on the matter requiring decision.”

4.63 The minority judgments in the *Gillick* case focused specifically on contraceptive treatment and the illegality of intercourse with a girl under 16, and passed little comment on the competency of minors to consent to medical treatment in general.⁷⁶ Lord Templeman did however draw a distinction between contraceptive treatment and other forms of treatment, stating that a doctor could, with the consent of an intelligent boy or girl of 15, remove tonsils or an appendix. The effect of the consent depends on the nature of the treatment and the age and understanding of the infant.⁷⁷

4.64 Although the *Gillick* case was heralded as a triumph for children’s rights, there are limits to its application. The standard of maturity laid down by the courts is very high, higher than the standard for adults in some respects.⁷⁸ A line of English cases dealing with minor’s refusal of medical treatment have been criticised as inconsistent with the fundamental principle of consent.⁷⁹

⁷⁵ Lord Scarman at 420.

⁷⁶ See chapter 3 at 3.87 for discussion of minority judgements.

⁷⁷ Lord Templeman at 432.

⁷⁸ Madden *Medicine, Ethics and the Law* (Butterworths 2002) at 486, Bainham *Children and the Modern Law* (Family Law 2005) at 355.

⁷⁹ See chapter 5 on refusal of medical treatment . Devereux et al “Can Children withhold consent to treatment?” (1993) 306 *British Medical Journal* at 1459, Huxtable “Re M (medical treatment: Consent) Time to remove the ‘flak jacket?’” (2000) *Child and Family Law Quarterly* 83 at 84.

4.65 The case of *R (Axon) v Secretary of State for Health*, discussed in Chapter 3 is a positive reinforcement of the importance of the rights of children in general and can be seen as an indication of growing respect for the autonomy of adolescents.⁸⁰ Although the case involved the provision of contraceptive advice and treatment, Silber J emphasised the general application of the principles laid down in *Gillick*.⁸¹

4.66 In relation to the claim concerning Article 8(1) of the European Convention on Human Rights, Silber J stated that the ECHR shows that the duty of confidence owed by a medical professional to a competent young person is a high one and should not be overridden except for a very powerful reason. Silber J also referred to the case of *Yousef v Netherlands 2003*⁸² and the statement by the European Court of Human Rights that, in judicial decisions where the rights under Article 8 of parents and of a child are at stake, the child's rights must be the paramount consideration.⁸³

4.67 Silber J also referred to the judgement of Thorpe LJ in,⁸⁴ that the right of articulate teenagers to freedom *Mabon v Mabon* of expression and participation outweighs the paternalistic judgement of welfare.⁸⁵ In *Mabon*, Thorpe LJ spoke of the keen appreciation of the autonomy of the child that has developed throughout the 21st century and the child's consequential right to participate in decision making processes that fundamentally affect him or her. Silber J stressed the importance of the Convention on the Rights of the Child, particularly articles 5, 12, 16 and 18⁸⁶ and the judgement in this regard seems placed within an international movement of heightened respect for children's rights.

4.68 Looking at the treatment of section 8 of the *Family Law Reform Act 1969* by the House of Lords in *Gillick* can provide some insights regarding the applicability of section 23 of the 1997 Act in Ireland, outside the criminal sphere. As section 23 of the *Non-Fatal Offences Against the Person Act 1997* is modelled on section 8 of the *Family Law Reform Act 1969*, it would seem reasonable to infer that section 23 would be dealt with in a similar way to

⁸⁰ [2006] EWHC 37 (Admin). See discussion in 3.95.

⁸¹ Silber J at 86.

⁸² [2003] 36 EHRR 20.

⁸³ Silber J at 65.

⁸⁴ [2005] 3 WLR, 460.

⁸⁵ Silber J at 78.

⁸⁶ Articles 5 and 12 are discussed in chapter 1 at 1.38 and 1.39.

section 8 in *Gillick*, if a comparable case came before the Irish courts. Nonetheless, the Commission has already referred to the unsuitability of a criminal statute to uphold the rights of children in the context of health care and consent to medical treatment. As already noted, commentators have called for legislation to clarify the ambiguity surrounding children and young people's capacity to consent to medical treatment. In its 1994 *Report on Non-Fatal Offences Against the Person*, the Commission briefly referred to the *Gillick* case, with the statement that it may or may not be followed in a civil case here:

“The *Gillick* decision might or might not be followed by our Supreme Court in a civil case but in criminal cases, certainty should be imported, where possible and we recommend that legislation be introduced similar to section 8 of the English Family Law Reform Act, 1969.”⁸⁷

4.69 Some commentators have pointed to Articles 41 and 42 of the Constitution, however, as potential barriers to a *Gillick* type outcome in Ireland.⁸⁸ Tomkin and Hanafin for example, have likened the Constitution's view of the child to Kant's or Locke's view of the child, as a being who has not yet attained 'reason' and therefore is not entitled to complete autonomy until he reaches the age of majority or 'reason'.⁸⁹ This view does not equate with the various rights and responsibilities that are granted to children and young people before they reach the age of majority, discussed in Chapter 2⁹⁰. Nor does such a view equate with the rights of the child, discussed in Chapter 1.⁹¹

4.70 Other commentators have also referred to the impact of Articles 41 and 42 of the Constitution in relation to the capacity of a child to consent to medical treatment. Kilkelly, for example, has stated that respect for the medical decision of a mature minor, in relation to contraceptive treatment, could interfere with the duty of parents to provide for the “religious and moral, intellectual, physical and social education of their children”. As against this argument, however Kilkelly, Donnelly and Madden have pointed to the personal rights of children and young people under the Constitution, such as a right to privacy

⁸⁷ Law Reform Commission *Report on Non-Fatal Offences Against the Person* (LRC 45-1994) at 9.169.

⁸⁸ Mc Mahon & Binchy *Law of Torts* (3rd ed Butterworths 2000) at 22.76, Madden *Medicine, Ethics and the Law* (3rd ed Butterworths 2002) at 490.

⁸⁹ Tomkin & Hanafin *Irish Medical Law* (Round Hall Sweet and Maxwell 1995) at 40.

⁹⁰ 2.03.

⁹¹ 1.04.

under Article 40.3.1.⁹² Madden has also stated that the area of adolescent autonomy ought to be reconsidered in the light of moves towards greater recognition of children's rights and rights of self-determination in the medical context generally.⁹³

(3) Scotland

4.71 Scottish law is based on the mature minor common law position, complemented by legislative measures. In 1987 the Scottish Law Commission published a *Report on the Legal Capacity and Responsibility of Minors and Pupils*⁹⁴, which was largely implemented by the *Age of Legal Capacity (Scotland) Act 1991*. The Scottish Law Commission approved the Canadian approach discussed at the Conference of Commissioners on Uniformity of Legislation in Canada in 1975.⁹⁵ The Scottish Commission repeated its earlier recommendation⁹⁶ that 16 should be the normal age at which a person could give an effective consent to medical treatment. This recommendation was supported by a flexible exception, namely that a person below the age of 16 should have capacity to consent to any surgical, medical or dental procedure or treatment if, in the opinion of a qualified medical practitioner attending that person, he is capable of understanding the nature and consequences of the treatment.⁹⁷

4.72 The Scottish Commission discussed the applicability of a requirement that the procedure and treatment should be in the young person's best interests, and concluded that the best interests test is too restrictive and unnecessary. If it is accepted that a child may consent if he is of sufficient maturity to understand the treatment proposed then the test of maturity should

⁹² Kilkelly & Donnelly *The Child's Right to be Heard in the Healthcare Setting* (Office of the Minister for Children 2006) at 24, Madden *Medicine, Ethics and the Law* (Butterworths 2002) at 490.

⁹³ Madden *Medicine, Ethics and the Law* (Butterworths 2002) at 490.

⁹⁴ Scottish Law Commission Report on the *Legal Capacity and Responsibility of Minors and Pupils* (Report 110 1987)

⁹⁵ As noted above, the *Medical Consent of Minors Act* was adopted at the Conference of Commissioners on Uniformity of Legislation in Canada in 1975.

⁹⁶ Scottish Law Commission *Legal Capacity and Responsibility of Minors and Pupils* (Consultative Memorandum No.65 1985) at 5.46.

⁹⁷ Scottish Law Commission Report on the *Legal Capacity and Responsibility of Minors and Pupils* (Report 110 1987) at 3.83.

be the determinative factor, whether the treatment concerned is in his or her best interests or not.⁹⁸

4.73 Section 2(4) of the *Age of Legal Capacity (Scotland) Act 1991* states:

“A person under the age of 16 years shall have legal capacity to consent on his own behalf to any surgical, medical or dental procedure or treatment where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences.”

4.74 In relation to children who are not sufficiently mature to consent to medical treatment, it is clear that their views must be heard. The Scottish Law Commission’s 1992 *Report on Family Law* recommended the introduction of a presumption that a child of 12 or more has sufficient maturity to express a reasonable view.⁹⁹ This does not carry any implication that the views of a child under that age are not worthy of discussion. The Commission took into account the fact that such presumptions of maturity are in force in Germany, Sweden, Norway and Finland. The recommendation was implemented by section 6 of *The Children (Scotland) Act 1995* which states:

“A person shall, in reaching any major decision which involves

(a) his fulfilling a parental responsibility or the responsibility mentioned in section 5(1) of this Act; or

(b) his exercising a parental right or giving consent by virtue of that section,

have regard so far as practicable to the views (if he wishes to express them) of the child concerned, taking account of the child’s age and maturity, and to those of any other person who has parental responsibilities or parental rights in relation to the child (and wishes to express those views); and without prejudice to the generality of this subsection a child twelve years of age or more shall be presumed to be of sufficient age and maturity to form a view.”

4.75 The approach taken by the Scottish Law Commission reflects the values enshrined in the Convention of the Rights of the Child and ensures a place for Article 12 of the Convention in domestic law.

⁹⁸ *Ibid* at 3.77.

⁹⁹ Scottish Law Commission *Report on Family Law* (Report 135 1992) at 2.65.

(4) Australia

4.76 The common law in Australia mirrors the *Gillick* mature minor approach. The High Court of Australia adopted the mature minor rule in *Secretary, Dept of Health and Community Services v JWB and SMB 1992*.¹⁰⁰ The case involved a dispute over the sterilisation of a 14 year old girl with significant intellectual disabilities. The girl in question did not have the capacity to make such a decision, but the court approved the *Gillick* case, stating that a minor, if competent, could consent to medical treatment:

“The proposition endorsed by the majority in that case was that parental power to consent to medical treatment on behalf of a child diminishes gradually as the child’s capacities and maturity grow and that the rate of development depends on the individual child.....This approach although lacking the certainty of a fixed age rule, accords with experience and psychology...It should be followed in this country as part of common law.”

4.77 In general, the capacity of a young person to consent to medical treatment is regulated by common law. In 1980, the Standing Committee of Commonwealth and State Attorneys-General referred an inquiry to the Western Australian Law Reform Commission in respect of the provision of medical treatment to minors with a view to recommending uniform legislation for enactment throughout Australia.¹⁰¹ The reference was withdrawn in 1984 due to insufficient resources. To date, legislation has been enacted in New South Wales and South Australia. The right of a minor to refuse medical treatment is rather unclear, discussed further in Chapter 5.

4.78 The Law Reform Commission of Western Australia, the Queensland Law Reform Commission, and more recently, in 2008, the New South Wales Law Reform Commission has examined the issue of young people’s consent to medical treatment.

(i) Western Australia

4.79 In 1988, the Law Reform Commission of Western Australia published a discussion paper on *Medical Treatment for Minors*. The Commission sought to strike a balance between the rights and responsibilities of parents which are exercised because, and only so long as, their children cannot look after

¹⁰⁰ 175 CLR 218.

¹⁰¹ New South Wales Law Reform Commission *Young People and Consent to Health Care* (Report 119 2008) at 113.

themselves, and on the other hand, the rights and duties of children.¹⁰² The Commission recommended that children aged 16 or older should be able to consent to medical treatment as if they were of full age, and the common law rights of mature children under the age of 16 to consent to medical treatment should be preserved. The Commission provisionally recommended a statutory scheme to that effect.¹⁰³

4.80 A research paper was published by the Commission of Western Australia in 1992 entitled *Informed Consent to Medical Treatment: Processes, Practices and Beliefs*.¹⁰⁴ The paper referred to empirical studies which show that minors, particularly those aged 14 or over are capable of being actively involved in treatment decisions.¹⁰⁵ A minor's ability to make a reasonable decision is dependent on the information available and the way in which that information is communicated to the minor. The research paper carried out a survey of minor patients and their physicians to determine what occurs in clinical situations. The survey found that there was a general presumption that parents would play an active role regarding the medical care provided to their child and there was little expectation on the part of physicians that the minor would participate in the decision making process.¹⁰⁶

(ii) Queensland

4.81 In 1996 the Queensland Law Reform Commission published a significant body of research on *Consent to Health Care of Young People*, including a draft bill based on different presumptions of maturity and capacity to consent for different age groups.¹⁰⁷ Under the draft Bill, which has not been enacted to date, the older age group of competent 16-17 year olds can consent to and refuse medical care, whilst the younger group of 12-15 year olds can

¹⁰² Law Reform Commission of Western Australia *Medical Treatment for Minors* (Discussion Paper 77-1 1988) at 5.1.

¹⁰³ The reference of the project was withdrawn in 1988. No recommendations had been made by the Commission upon that reference. [http://www.lrc.justice.wa.gov.au/2publications/summaries/P77\(1\).PDF](http://www.lrc.justice.wa.gov.au/2publications/summaries/P77(1).PDF)

¹⁰⁴ Production of the final report was suspended in 1993 and the reference was withdrawn in 1998.

¹⁰⁵ Law Reform Commission of Western Australia *Informed Consent to Medical Treatment* (Research Report 1992) at 29.

¹⁰⁶ *Ibid* at 127.

¹⁰⁷ Queensland Law Reform Commission *Consent to Health Care of Young People: Volume Three* (Report 51 1996).

consent to treatment if the young person in question understands the nature and consequences of the particular health care decision.¹⁰⁸

(iii) New South Wales

4.82 In New South Wales, the common law test of maturity interacts with Section 49 of the *Minors (Property and Contracts) Act 1970* which sets the minimum age of consent at 14 years, by stating that a person who gives medical or dental treatment to a person under the age of 16 is only protected from liability if a parent or guardian has consented. If a practitioner performs medical or dental treatment on a person 14 years or older with the consent of that person, the practitioner is similarly protected from liability. The aim of the provision is to protect medical practitioners, acting with reasonable care and consent, from civil liability. Rather like section 23 of the *Non-Fatal Offences Against the Person Act*, section 49 does not expressly confer a general capacity on young people to consent or refuse medical treatment.¹⁰⁹ The interaction of section 49 with the common law has created much confusion, as much of the common law on the matter developed after 1970, surpassing the limitations of section 49 and rendering it redundant.

4.83 In its report, the New South Wales Law Reform Commission recommended that section 49 should be repealed. The report on *Young People and Consent to Healthcare* was published in 2008, following the publication of an Issues Paper in 2004.¹¹⁰ The Commission set out a number of aims to guide reform of the law in this area, such as: promoting good health care amongst young people by ensuring access to health care, acknowledging the involvement of parents and family members in children's health care, the responsibility of State and parents to protect young people from harm and ensuring that young people are free to make a choice about what is done to their bodies.

4.84 The Commission recommended the introduction of legislation to regulate the decision-making process regarding health care for young people. Legislation would state that a young person is competent to refuse or accept health care if, in the opinion of the health care practitioner, the young person understands the information that is relevant to making a decision about the

¹⁰⁸ *A Bill for an act regulating authorisation of health care of young people, and for other purposes*. Queensland Law Reform Commission *Consent to Health Care of Young People: Volume Three* (Report 51 1996).

¹⁰⁹ New South Wales Law Reform Commission *Minors Consent to Medical Treatment* (Issues Paper 24 2004) at 31.

¹¹⁰ The report was tabled in the legislative assembly in March 2009. See <http://www.lawlink.nsw.gov.au/lrc.nsf/pages/digest.106>

health care, and appreciates the reasonably foreseeable consequences of that decision. A young person aged 16 years and over is presumed to be competent to make such a decision, however this presumption can be rebutted. As discussed in Chapter 3¹¹¹, the New South Wales Law Reform Commission felt there was a compelling argument that in certain situations, young people who are not competent to consent should have access to medical treatment, where the treatment is necessary and promotes their health and well-being.¹¹²

(iv) South Australia

4.85 In South Australia, the *Consent to Medical Treatment and Palliative Care Act 1995* provides a statutory framework to deal with issues of consent to health care by adults and young people. Section 6 of the 1995 Act states that a person aged 16 years and over may make decisions about his or her own medical treatment as validly and effectively as an adult. Section 12 states that for young people under 16, the consent of either a parent or the young person is effective. The young person below the age of 16 must be deemed competent in the eyes of the treating doctor, supported by the written opinion of a second medical practitioner. The treatment must also be in his or her best interests. A parent may be able to seek a court order prohibiting, in the interests of a young person, performance of health care to which the young person has consented. The court would then have to adjudicate the dispute according to the principle that the welfare of the young person is paramount.

(5) New Zealand

4.86 Aside from the common law, there are several legislative provisions which must be discussed in relation to the age of consent to medical treatment in New Zealand. Section 25 of the *Guardianship Act 1968*, replaced by Section 36 of the *Care of Children Act 2004* was similar to section 8 of the UK *Family Law Reform Act 1969*, which in turn seems to have inspired section 23 of the *Non-Fatal Offences Against the Person Act 1997* in Ireland. Section 25 of the *Guardianship Act* gave 16 year olds the statutory capacity to consent to medical, surgical or dental procedures, if the procedures were for the benefit of the patient and carried out by a qualified professional.¹¹³ The consent of minors who were married was accorded full legal effect. Section 25, like section 8 of the 1969 UK Act and section 23 of the 1997 Irish Act, was silent on the question of consent to medical treatment by children under 16 years of age.

¹¹¹ 3.110

¹¹² New South Wales Law Reform Commission *Young People and Consent to Health Care* (Report 119 2008) at 172.

¹¹³ Section 25(1) the *Guardianship Act 1968*.

4.87 Section 25 of the 1968 Act was enacted, in the same form, in the *Care of Children Act 2004*. Section 36 states that a consent or refusal to any medical, surgical or dental treatment or procedure, (including blood transfusions) given by a child over the age of 16 has effect as if the child were of full age.¹¹⁴

4.88 Under section 36(2) young people who are married, in a civil union or living with another person in a de facto partnership can consent to and refuse medical treatment for themselves or for any other person (child) as if they were of full age.¹¹⁵ Like its predecessor, section 36 of the 2004 Act is silent as to the legal capacity of a minor under the age of 16 to consent to medical treatment. It has been argued however, that the common law rights of a mature minor to consent to medical treatment have not been limited by the statutory provisions.¹¹⁶ Skegg states:

“the better view is that minors common law capacity to consent to medical treatment has not been extinguished by the New Zealand legislation, and that the consent of those under the age of 16 will sometimes be effective in law....¹¹⁷”

4.89 Furthermore, it seems that in practice, there is acceptance of a capacity based approach to consent by the medical profession.¹¹⁸ A guideline

¹¹⁴ The *Care of Children Act 2004* replaced the *Guardianship of Infants Act 1968*. Section 25 of the *Guardianship of Infants Act* was similar to section 23 of the *Non-Fatal Offences Against the Person Act 1997* and did not empower a young person to refuse treatment.

¹¹⁵ New South Wales Law Reform Commission *Young People and Consent to Health Care* (Report 119 2008) at 125.

¹¹⁶ Mc Dowell “Medical Treatment and Children: Assessing the Scope of a Child’s Capacity to Consent or Refuse to Consent in New Zealand” (1997) 5 *Journal of Law and Medicine* 81 at 92, Thompson “Whose Right to Choose? A Competent child’s Right to Consent to and Refuse Medical Treatment in New Zealand” (2001-2002) 8 *Canterbury Law Review* 145 at 171.

¹¹⁷ Skegg & Paterson *Medical Law in New Zealand* (Thompson Brookers 2006) at 189.

¹¹⁸ McLean “Children and Competence to Consent: Gillick Guiding Medical Treatment in New Zealand” (2000) 31 *Victoria U Wellington L Rev* 551 at 555, Thompson “Whose Right to Choose? A Competent child’s Right to Consent to and Refuse Medical Treatment in New Zealand” (2001-2002) 8 *Canterbury Law Review* 145 at 177.

document produced by the Ministry of Health states that a practitioner must judge whether a particular child is competent to give informed consent to a particular procedure.¹¹⁹

4.90 The *Code of Health and Disability Services Consumers Rights 1996* enshrines the principle of informed consent and informed choice. 7(1) states that:

“Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.”¹²⁰

4.91 The Code creates a presumption of competence, unless there are reasonable grounds for believing that the consumer is not competent. The provisions of the Code, including the presumption of competence, are applicable to all health consumers.

(6) Conclusion

4.92 It is notable that Australia, Canada, England, Scotland and New Zealand have all adopted the mature minor rule, with various states and provinces also incorporating the rule in statutory form. Law reform bodies in other countries have recognised the mature minor rule as a method of ensuring that competent children and young people are not denied medical treatment and also assuring health care professionals that they can legally treat competent children and young people. It is interesting to note that a number of the law reform bodies have referred to the significant public policy aspect involved in this area of law, namely that it is in the best interests of society for children and young people to have access to medical treatment and advice.

Ministry for Health *Consent in Child and Youth Health: Information for Practitioners* (New Zealand 1998) at 13.

¹¹⁹ Ministry for Health *Consent in Child and Youth Health: Information for Practitioners* (New Zealand 1998) at 24-26.

¹²⁰ 7(1) of the *Code of Health and Disability Services Consumers Rights 1996*.

D Discussion on Age at Which Children are Competent to Consent to Medical Treatment

(a) *Rights of the Child in the Health Care Setting*

4.93 When examining various national and international human rights instruments, the Commission can identify a discernable emphasis on the rights and voice of the child.¹²¹ Children are entitled to more than a minimum level of care and protection provided by their families. They are individual rights holders whose rights are self standing and not a consequence or derivative of the rights of their parents. It is within this atmosphere we must address children's capabilities and capacity to consent, and their right to consent, or at a minimum participate, in decisions regarding their medical treatment.

4.94 Irish law, encompassing constitutional, statute and case law, contains few references to children's rights to health care. There is no statutory provision dedicated to children, guaranteeing access to health care services and detailing their rights in the health care system. Despite the existence of a range of different documents focusing on specific issues such as alcohol use and mental health, there is no single document setting out suitable standards of care for children, guidelines for treating children in hospital, and appropriate levels of participation by children.¹²²

4.95 Furthermore, there is no requirement to listen to the wishes of the child in the health care setting, or recognition of the right of the child to voice an opinion regarding his or her medical treatment. There are no formal guidelines as to how doctors should weigh up the interests of the child, the wishes of the parents and their own professional opinion.

4.96 A report published in 2006 by the Office of the Minister for Children examined the extent to which children's voices are being heard in the health care setting throughout Ireland.¹²³ A total of 52 children were interviewed, varying in age, gender, background and level of contact with the health care system. The interviewees consistently identified the importance of being heard by health care professionals and expressed a desire to be understood and provided with age-appropriate explanations and information. The report articulated a need to raise awareness amongst parents regarding children's right to be heard, and the need to ensure that health care professionals receive

¹²¹ See 1.35.

¹²² Kilkelly, *Children's Rights in Ireland* (Tottel Publishing 2008) at 405.

¹²³ Kilkelly & Donnelly *The Child's Right to be Heard in the Healthcare Setting* (Office of the Minister for Children 2006).

the necessary skills and training on how to communicate with both parents and children in the health care setting.

4.97 A 2008 literature review of children's participation and decision-making within the health care setting revealed that children are rarely consulted and seem to play a marginalised role in health care discussions and decisions.¹²⁴ Both health care professionals and parents have a significant influence on whether a child's efforts to participate are facilitated and supported. There remains much uncertainty and divergence of opinion amongst parents and health care professionals regarding levels of participation by children in medical decision-making. It is not easy for children to participate in a health care system which is traditionally paternalistic. They face obstacles primarily from healthcare professionals, and also parents. As discussed in Chapter 1, evidence suggests that children would like to participate more in decision making and there are many benefits associated with participation.¹²⁵ The Commission's consultation with children and young people confirmed this view.

4.98 Additional research has been called for as there is a shortage of information on children's preferences and the role they would like to play in medical consultation and decision-making.¹²⁶ Studies from the UK indicate that both health care professionals and children would agree with a reduction in the age at which children are competent to consent to medical treatment however this is qualified by the finding that personal experience is more significant than age in relation to capability to deal with medical issues and decision-making.¹²⁷

4.99 An Irish study differs in some ways in its findings, which points to possible misconceptions and highlights the need for further research to fully ascertain the opinions of children, parents and health care professionals here in Ireland. As part of a research study carried out in 2008, parents, children and staff in a Dublin hospital were asked if they agreed with the current age of 16 years for independent consent to medical treatment. 85% of nurses and 90% of doctors felt the current age is appropriate with few stating that children under 16 should have independent consent to medical treatment. When asked however if

¹²⁴ Coyne "Children's participation in consultations and decision-making at health service level: A review of the literature" (2008) 45 *International Journal of Nursing Studies* 1682 at 1682.

¹²⁵ 1.78.

¹²⁶ Coyne "Children's participation in consultations and decision-making at health service level: A review of the literature" (2008) 45 *International Journal of Nursing Studies* 1682 at 1687.

¹²⁷ Alderson "Making a Wise choice: Competence to Consent" in *Children's Consent to Surgery* (Open University Press 1993) at 152-171.

children under 16, who were deemed competent should be granted independent consent, numbers increased significantly.¹²⁸

4.100 Parents did not feel that children under the age of 16 should consent independently to medical treatment and 82% of parents felt that children should be 17 years or older. 58% of children felt that such consent should be delayed until they reached 18 years of age, whilst 30% agreed with the current age of 16 years. It is interesting to note the significant correlation between children with numerous hospital admissions and those who felt that children under 16 years of age should be deemed competent to consent to medical treatment. Experience and involvement in the health care setting is a highly relevant factor in determining a child's ability to understand health care issues.¹²⁹ A subjective approach in relation to the ability of a child or young person to participate in health care decisions is needed as opposed to a general objective view.

4.101 An important point to make in this regard is that granting a competent young person the legal ability to consent to medical treatment does not mean that his or her parents are excluded from the decision making process. Ideally speaking, particularly in the case of a child with a serious illness, decisions will be taken collectively, with input from the patient, parents and health care professionals.

(b) International Obligations

4.102 Looking beyond domestic law, attention must be paid to the significant collection of international instruments promoting children's rights. In this respect it has been noted that family law in particular is undergoing a process of "internationalisation".¹³⁰ As discussed in chapter one, there is a substantial body of law which serves to emphasise and promote the rights of children to participate in matters affecting them, including health care and treatment decisions.¹³¹

¹²⁸ 18% of nurses and 26% of doctors stated that children under 16 should be able to give consent independently, however with the condition of competency, these figures increased to 41% and 49% respectively.

¹²⁹ This correlates with previous research. See generally Alderson & Montgomery, *Health Care Choices: Making Decisions with Children* (Institute for Public Policy Research, London, 1996) at 198.

¹³⁰ Shannon "The Internationalisation of Irish Family Law" (2005) 5 *Judicial Studies Institute Journal* 42 at 45. The Irish Times "Rights-based approach to child law now widespread" 7/12/2009.

¹³¹ 1.39.

4.103 Article 12 of the 1989 UN Convention on the Rights of the Child states that children have a right to express their views on all matters affecting them, which in turn should be taken into account in accordance with the age and maturity of the child in question. A child's right to be heard and have his views taken into account in accordance with his age and maturity is thus clearly set out in Article 12 of the Convention. Some limited statutory expressions have been given to this duty for example section 25 of the *Child Care Act 1991* but the principle is not consistently applied in the Irish health care system.¹³² In the Commission's view, this can be traced to the absence of a suitable legislative framework and formal guidelines setting out the right of the child to be involved in the health care setting.¹³³

4.104 The 2004 *General Comment on Adolescent Health and Development* by the Committee on the Rights of the Child stated that the 1989 UN Convention confers an obligation on State Parties to:

“ensure that adolescents have access to the information that is essential for their health and development and ...have opportunities to participate in decisions affecting their health”¹³⁴

4.105 In 1998 the UN Committee on the Rights of the Child expressed concern that Ireland's welfare policies and practices did not adequately reflect the child rights-based approach enshrined in the Convention on the Rights of the Child. The Committee pointed to the lack of adequate and systematic training on the principles and provisions of the CRC for professional groups, including health professionals, working with and for children.¹³⁵

4.106 As discussed in chapter one, the European Convention on Human Rights has added greatly to the growing body of jurisprudence on the rights of children. The approach of the European Court of Human Rights to the definition of family life offers great opportunity to protect all family members, including children.¹³⁶

¹³² Section 25 of the *Child Care Act 1991* is discussed in further detail in chapter 6 at 6.80.

¹³³ See Kilkelly, *Children's Rights in Ireland* (Tottel Publishing 2008) at 408.

¹³⁴ Committee on the Rights of the Child “*Adolescent health and development in the context of the Convention on the Rights of the Child*” (General Comment No 4 of 2003 CRC/GC/2003/4 1 July 2003) at 39(b).

¹³⁵ UN Committee on the Rights of the Child *Concluding Observations of the Committee on the Rights of the Child: Ireland* February (1998) at 11.

¹³⁶ Kilkelly, “Children's Rights: A European Perspective” (2004) 4 *Judicial Studies Institute Journal* 68 at 95.

4.107 The Council of Europe 1997 Convention on Human Rights and Biomedicine is an expression of the need to preserve human dignity, rights and freedoms from the misuse of biological and medical advances.¹³⁷ Article 6 provides for a representative to give consent where a minor does not have capacity, and states that the opinion of the minor shall be taken into consideration as an increasingly determining factor in proportion to his or her age and degree of maturity.

4.108 Article 24 of the Charter of Fundamental Rights of the European Union, which forms part of EC law under the Lisbon Treaty also recognises the rights of children to express their views and have their views considered in accordance with their age and maturity. The Charter has the potential to strengthen the high level of protection of the rights of children in EU law, already to be found in for example, the 2002 Brussels II bis Regulation on the recognition of judgments in family proceedings. This provides that a court order will not be recognised in another EU member State unless the voice of the child has been heard.

4.109 As mentioned above, there is no statutory guidance in Ireland on the treatment of children in hospital. In 1988 the European Association for Children in Hospital adopted a Charter of Rights which sets out a number of principles and a list of rights for all children at different stages of hospital care. The Charter is a non binding instrument, and applies to all children under 18 years of age in line with the rights articulated in the 1989 Convention of the Rights of the Child. Article 4 states that children and parents have the right to be informed in a manner appropriate to age and understanding. The article also highlights a child's right to confidentiality in certain situations.

“children have the right to express their own views and providing they have sufficient competence to understand the matter, they may veto their parents access to their health information”

4.110 Article 5 provides recognition of the right of parents and children to informed participation in all decisions involving their health care.

4.111 In 2008, a research study was carried out to examine if Irish hospitals adhere to the Charter of Rights. A number of shortcomings were identified, including a lack of paediatric training amongst staff and a shortage of facilities for older children such as age appropriate wards.¹³⁸ Regarding information given to children in relation to their condition and treatment, only 50% of nurses and 59% of doctors encouraged children to ask questions. 72% of children

¹³⁷ Ireland has not signed the convention.

¹³⁸ Migone, et al “Are we following the European Charter?” 34(4) *Child: care, health and development* (2008) 409 at 409.

stated that they would like to receive as much information as possible, whilst 28% preferred their parents to receive the information, and subsequently discuss it with them. There was a significant correlation between children with numerous hospital admissions and those who wanted to know as much as possible about their treatment. Children who receive information gain a sense of understanding and control which can reduce anxiety.¹³⁹

E Conclusions and Provisional Recommendations

4.112 In the Commission's view, respect for the autonomy and dignity of the child requires the facilitation, where possible, of the child's right to make his or her own decisions. Guidelines on treatment of children generally provide that the child's wishes should be taken into account and given more weight in accordance with the child's age and increasing maturity. Young children may not have the requisite understanding or experience to make decisions concerning their medical treatment however they may be capable of expressing views on the costs and benefits of a particular course of action.

4.113 The Government's 2000 National Children's Strategy contains several key objectives which should guide future policy on children. One of the key goals set out in the strategy document is that children will have a voice in matters which affect them and their views will be given due weight in accordance with their age and maturity. The strategy outlined the importance of including children in decision making and recognises that children have an active contribution to make in shaping their own lives:

"It is important that giving children a voice is not interpreted as passing responsibility for decisions and their consequences to children. The intention is to ensure that in achieving a decision which is in the best interests of the child, the child should have an active part and know that his or her views are respected."¹⁴⁰

4.114 The Law Society of Ireland's Law Reform Committee has recommended, as a general principle, that doctors be required by law to give children an opportunity to express their views and give them due weight in accordance with their age and maturity.¹⁴¹ The Commission concurs with this

¹³⁹ See generally Alderson, *Children's Consent to Surgery* (Open University Press 1993).

¹⁴⁰ *The National Children's Strategy: Our Children Their Lives* (Stationary Office Dublin 2000) at 3.1.

¹⁴¹ Law Society's Law Reform Committee *Rights-based Child Law: The Case for Reform* (Law Society of Ireland 2006) at 187.

approach, which complements the provisional recommendation made in Chapter 3.¹⁴² Accordingly, the Commission provisionally recommends that, when treating children, health care professionals grant children an opportunity to express their views and give their views due weight, in accordance with the child's age and maturity.

4.115 *The Commission provisionally recommends that, when treating children, health care professionals grant children an opportunity to express their views and give their views due weight, in accordance with the child's age and maturity.*

4.116 As the Commission has already noted, the existing legislation in Ireland regarding a child's consent to medical treatment, section 23 of the *Non-Fatal Offences Against the Person Act 1997*, provides a medical practitioner with a defence to a prosecution for assault. It was clearly not enacted to deal with the wider issue of the self determination of children. In the Commission's view, there is a fundamental difference between the acknowledgment of child's right to bodily integrity and autonomy, and the creation of a defence to the criminal offence of assault.

4.117 The Commission, has, therefore, provisionally concluded that it should be provided in legislation that a person who is 16 years of age is presumed to have capacity to consent to medical treatment. The word presumption in this regard is intended to reflect the presumption in law that a person of 18 years has full capacity.

4.118 If a 16 year old does not have the requisite capacity to consent to medical treatment, he or she is treated in a similar manner to an adult patient who does not have capacity. In such a case, the medical practitioner must take reasonable steps to find out if any other person has legal capacity to make decisions on behalf of the patient. In relation to persons under 18 years of age, their parents will have the legal capacity to make health care decisions which is in their best interests.¹⁴³

4.119 *The Commission provisionally recommends that it should be provided in legislation that a person who is 16 years of age is presumed to have capacity to consent to health care and medical treatment. The word*

¹⁴² At 3.50 "The Commission provisionally recommends that, in recognition of Article 12 of the 1989 UN Convention on the Rights of the Child, a child who is capable of forming his or her views has the right to express those views freely in all matters affecting him or her and that the views of the child should be given due weight in accordance with his or her age or maturity."

¹⁴³ The Medical Council *Guide to Professional Conduct and Ethics For Registered Medical Practitioners* (7th ed 2009) at 35.

presumption in this regard is intended to reflect the presumption in law that a person of 18 years has full capacity.

4.120 Under the 1997 Act, the ability to give consent is based solely on an individual's age rather than understanding or capacity to consent to medical treatment. The Commission's 1994 *Report on Non-Fatal Offences Against the Person* stated that a minor is not incapable of giving an effective consent by reason of their minor status only:

"In all cases it is a question of whether the patient is capable of understanding the essential nature, purpose and likely effects of the treatment in question."¹⁴⁴

4.121 Generally speaking, the law on capacity is moving away from the traditional status approach to capacity which involved an "all or nothing" type of assessment. In its 2006 *Report on Vulnerable Adults and the Law*, the Commission stated:

"At the most fundamental level, the Commission does not favour the status approach to capacity because, rather than being capacity and autonomy-building in nature, this approach to capacity is unnecessarily disabling in its effect. Operating at a macro level, the status approach does not take a micro view of the capacity to make decisions in a particular decision-making sphere."¹⁴⁵

4.122 The Commission recommended a functional approach to capacity whereby capacity is assessed in relation to the particular decision to be made, at the time it is to be made. In relation to decisions on health care, the Commission also recommended that capacity should be assessed on the basis of a functional test of capacity. An application of the functional test to an assessment of a child's capacity may reveal that, although the child in question does not have the capacity to participate in various adult affairs, he or she has the capacity to participate in the management of his or her future medical care.

4.123 The Ombudsman for Children promotes a rights-based approach to health care for children and rejects the use of chronological age as a

¹⁴⁴ Law Reform Commission *Report on Non-Fatal Offences Against the Person* (LRC 45-1994) at 9.165.

¹⁴⁵ Law Reform Commission *Report Vulnerable Adults and the Law* (83-2006) at 2.25.

determinant of capacity.¹⁴⁶ Children do not go through the same transitions at the same time.¹⁴⁷

4.124 Much of the literature on the subject suggests that age is no longer an appropriate scale to measure a child's maturity. Piaget's research and developmental theory indicate that children go through stages of development, developing the capacity to make an intelligent choice at the age of 11 or 12. At this stage, children have the ability to use deductive and inductive reasoning, apply reason to hypothetical situations, weigh up alternative options, and think about the future.¹⁴⁸ Whilst there are different opinions and theories regarding the cognitive development of children, there is a general consensus regarding the difference between the thought processes of children and adolescents. Children tend to view situations in black and white, focused on the present tense whilst adolescent thinking is multi-dimensional, with an ability to think and plan for the future.¹⁴⁹ It seems that the majority of older adolescents are equipped with the skills for quite sophisticated evaluation and decision-making.¹⁵⁰ However adolescence is a time of rapid change, experimentation and questioning of traditional beliefs. One cannot therefore disregard the experience and maturity of the individual adolescent, in relation to the particular decision at hand. Assumptions and generalisations about what decisions can be made at what age can never be wholly accurate. In general, personal experience and understanding are more relevant and determinative of a particular child's ability to understand and make informed decisions regarding his or her medical care.

4.125 Research carried out in England studied a group of children with diabetes.¹⁵¹ The results revealed that children can have a much more sophisticated capacity for taking charge of their own health care decisions than

¹⁴⁶ Logan "The Rights of Children in Healthcare: the Views of the Ombudsman for Children" (2008) 14(2) *Medico- Legal Journal of Ireland* at 69.

¹⁴⁷ *Ibid.*

¹⁴⁸ Piaget *The Psychology of the Child* (Basic Books 1969).

¹⁴⁹ Fortin *Children's Rights and the Developing Law* (2nd ed Butterworths 2003) at 72.

¹⁵⁰ Christie & Viner "ABC of adolescence: Adolescent Development"(2005) 330 *British Medical Journal* 301 at 302, Larcher "ABC of Adolescence: Consent, competence and confidentiality" (2005) *British Medical Journal* 330 at 353, Fundudis "Consent Issues in Medico-Legal Procedures: How Competent Are Children to Make Their Own Decisions?" (2003) 8(1) *Child and Adolescent Mental Health* 18 at 18.

¹⁵¹ Alderson "Children's Competence to Consent to Medical Treatment" (2006) 36 (6) *Hastings Centre Report* at 25.

is usually recognised. Children as young as 4 years old understood the general principle of managing glycaemia levels and taking responsibility for decisions which affected their health. Many of the children interviewed performed their own blood tests and injections, including two six year olds. Children learned to plan their carbohydrate intake based on various factors such as glycaemic level, insulin dose, planned activities and so on. The children who displayed the best levels of control over their illness were those who were most informed and trusted with their own health care decisions.

4.126 It is clear that cases involving particular circumstances and individuals will arise and necessitate a divergence from rigid distinctions based solely on age. The law must allow for specific cases where a child's personal experience and knowledge vastly outweighs an expected level of maturity based solely on age. The Commission has, therefore, provisionally concluded that a functional capacity test should be used in the context of consent to medical treatment by persons under 16 years of age.

4.127 *The Commission provisionally recommends that a person who is 14 years of age but less than 16 years of age could, subject to certain requirements, be regarded as capable of giving consent to health care and medical treatment, provided he or she has the capacity to understand the nature and consequences of the treatment being provided. Such requirements would include:*

- *In the opinion of the medical practitioner, the patient understands the nature and consequences of the proposed treatment*
- *The medical practitioner shall encourage the patient to inform his or her parents or guardians*
- *The medical practitioner must consider the best interests of the patient.*
- *The medical practitioner shall have due regard to any public health concerns*

4.128 *The Commission provisionally recommends that it shall be lawful for a health care professional to provide health care and medical treatment to a person who is 12 years of age but less than 14 years of age, provided that the health care professional has complied with certain requirements. Such requirements would include:*

- *It is mandatory for the medical practitioner to notify the parents guardians of the child and take account of their views*
- *The medical practitioner must take account of the views of the child in question*

- *The medical practitioner must consider the best interests of the patient.*
- *The medical practitioner shall have due regard to any public health concerns*

These recommendations shall not legalise any health care treatments that are prohibited or shall be prohibited in any other statutory form.

CHAPTER 5 REFUSAL OF MEDICAL TREATMENT

A Introduction

5.01 In this chapter, the Commission examines refusal of medical treatment. Part B looks at Irish law on refusal of medical treatment, primarily in the context of refusal by an adult. Part C addresses the issues raised by refusal of medical treatment by a minor, including a comparative analysis from other countries. The issues are discussed in further detail in Part D. In Part E, the Commission discusses options for reform and also addresses the question of advance care directives for persons under 18 years of age.

B Irish Position on Refusal of Medical Treatment

5.02 There is no Irish case law on the legal status of a minor's refusal to medical treatment. Much of the debate in relation to refusal of treatment has centred on the decision of the terminally ill adult patient to refuse life sustaining treatment. The courts have yet to address issues of autonomy and bodily integrity in the context of refusal of medical treatment by a minor patient.

5.03 The cases briefly discussed in the following paragraphs confirm the importance of respect for autonomy, dignity and bodily integrity in the context of refusal of medical treatment. The discussion also explains how the test of capacity employed to assess such a decision is a functional one which is time and issue specific.

(a) *Re Ward of Court (No 2) 1996*

5.04 The decision of the Supreme Court in *Re a Ward of Court (No2)*¹ set out the current Irish law on refusal of medical treatment by an adult. This case involved a 46 year old woman, who had suffered severe brain damage 24 years previously and had since been in a near persistent vegetative state. Her mother applied for directions from the courts as to the proper care and treatment of her daughter. The core issue of the case was whether it was permissible in Irish law to withdraw the medical treatment, in particular the form of artificial nutrition and hydration being given to her.

¹ [1996] 2 IR 79.

5.05 Hamilton CJ stated:

“A competent adult, if terminally ill has the right to forego or discontinue life-saving treatment... and the exercise of that right would be lawful and in pursuance of [the person’s] constitutional rights”²

5.06 Similarly, O Flaherty J stated:

“consent to medical treatment is required in the case of a competent person... and, as a corollary, there is an absolute right in a competent person to refuse medical treatment even if it leads to death.”³

5.07 He considered that “it would be correct to describe the right in our law as founded both on the common law as well as the constitutional rights to bodily integrity and privacy.”⁴ Denham J agreed, adding that: “...medical treatment may be refused for other than medical reasons, or reasons most citizens would regard as rational, but the person of full age and capacity may make the decision for their own reasons.”⁵

5.08 The Supreme Court has clearly recognised the constitutional right of personal autonomy, stating that a competent person of full age and capacity has the right to refuse medical treatment, even though the consequence of refusal may lead to death.

(b) *Fitzpatrick v FK 2008*

5.09 In *Fitzpatrick v FK*,⁶ the High Court ordered that a 23-year old Congolese woman (Ms K) who had refused a blood transfusion should be given the transfusion against her will in order to save her life.

5.10 The case came before Laffoy J in *Fitzpatrick v FK (No 2)*⁷ to determine whether the transfusion had been lawfully given. In determining whether a patient is deprived of capacity to make a decision to refuse medical treatment, Laffoy J states that the test is:

“whether the patient’s cognitive ability has been impaired to the extent that he or she does not sufficiently understand the nature,

² *Re a Ward of Court (No2)* [1996] 2 IR 79 at 125-6.

³ *Ibid* at 129.

⁴ *Ibid*.

⁵ *Ibid* at 156.

⁶ [2008] ILRM 68.

⁷ [2008] IEHC 104.

purpose and effect of the proffered treatment and the consequences of accepting or rejecting it in the context of the choices available (including any alternative treatment) at the time the decision is made.”⁸

5.11 The Commission notes that this decision-specific cognitive test of mental capacity is consistent with the Commission’s recommendation in its 2006 *Report on Vulnerable Adults and the Law*⁹ and this is also included in the Government’s *Scheme of a Mental Capacity Bill 2008*.

5.12 Laffoy J stated that the three-stage approach to the patient’s decision-making process adopted in the English case *Re C*¹⁰ is a “helpful tool” in applying that test **Error! Bookmark not defined.**¹¹. In applying *Re C* to the facts of the case Laffoy J held, first, that Ms K did not sufficiently understand and retain the information given to her by the Hospital personnel as to the necessity of a blood transfusion to preserve her life; second, that she did not believe that information and, in particular, that she did not believe that she was likely to die without a blood transfusion being administered; and finally, that in making her decision to refuse a blood transfusion, Ms K had not properly weighed that information in the balance, balancing the risk of death inherent in that decision and its consequences, including its consequences for her newborn baby, against the availability of a blood transfusion that would preserve her life.

5.13 Laffoy J held that Ms K’s clinicians had given her the information necessary to enable her to make an informed decision as to whether to accept or refuse a blood transfusion. That information was conveyed in terms from which a competent adult whose capacity was not impaired should have understood the gravity of the situation.

5.14 The assessment of capacity must have regard to “the gravity of the decision, in terms of the consequences which are likely to ensue from the acceptance or rejection of the proffered treatment.” Laffoy J rejected the suggestion of Ms K’s counsel that the patient’s capacity should be measured against the nature of the decision, rather than its consequences, citing the

⁸ Citing Lord Donaldson in *Re T (refusal of medical treatment)* [1992] 4 All ER 649.

⁹ Law Reform Commission *Vulnerable Adults and the Law* (LRC 83-2006).

¹⁰ [1994] 1 WLR 290.

¹¹ Laffoy J specifically noted that the Commission’s proposed statutory functional test of capacity (in the 2006 *Report on Vulnerable Adults and the Law*) was consistent with the test in *Re C*.

decision of the Supreme Court in *Re a Ward of Court (No 2)*¹² in support. When refusing a blood transfusion, Ms K had suggested to the Master of the Hospital that Coca-Cola and tomatoes might be an alternative solution to a blood transfusion. Laffoy J held that this suggestion could “only ring alarm bells” as to Ms K’s appreciation of the gravity of the situation when viewed objectively.

5.15 Laffoy J concluded that Ms K’s capacity was impaired to the extent that she did not have the ability to make a valid refusal to accept a blood transfusion. Therefore, the administration of the transfusion was not an unlawful act, and did not constitute a breach of her rights either under the Constitution or the Convention.

5.16 It is clear that the case turned on the issue of capacity and whether her capacity was impaired to the extent that she could no longer give an informed consent or refusal. The Supreme Court pointed out in the *Ward of Court* case that the corollary to the right to consent to treatment is the right to refuse treatment.¹³ Applying this approach to minors, if a minor has the legal and cognitive capacity to consent to treatment, this must also include the capacity to refuse treatment.

C The Minor Patient and Refusal of Medical Treatment

(1) Ireland

5.17 As explained in chapter 4, there is much ambiguity surrounding issues of a minor’s legal capacity to consent to medical treatment.¹⁴ Such ambiguity however is even more pronounced in the context of the legal capacity of a minor to refuse medical treatment.

5.18 The recent guidance of the Medical Council briefly states that a refusal of treatment by a patient between 16 and 18 years, against medical advice and parental wishes, is of uncertain legal validity.¹⁵ There is no distinction made between medical advice and parental wishes, which may be at variance. Nor is there a distinction drawn between essential or life sustaining treatments and other treatments which are not so indispensable. It seems, from the point of view of the medical profession, that a 16 year old may consent to medical treatment however his or her purported refusal of medical treatment evokes a need for legal advice.

¹² [1996] 2 IR 79.

¹³ O Flaherty J at 129.

¹⁴ At 4.02.

¹⁵ Medical Council *A Guide to Ethical Conduct and Behaviour* (7th ed 2009) at 41.

5.19 As the Commission has already noted in Chapter 4,¹⁶ section 23 of the *Non-Fatal Offences Against the Person Act 1997* refers only to consent in the context of providing a defence to a prosecution under the 1997 Act:

“The consent of a minor who has attained the age of 16 years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his or her person, shall be as effective as it would be if he or she were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his or her parent or guardian”

5.20 The right to refuse treatment is often viewed as the natural corollary of the right to consent and therefore one could argue that, under the 1997 Act, a person who has attained the age of 16 years can consent to and therefore refuse medical treatment. The wording “as effective as it would be if he or she had attained full age” is significant, because the refusal of a person of full age is treated as a corollary of consent; therefore the refusal of a person who has attained 16 years of age could also be viewed as a corollary of consent. Clarity however is called for as such speculation does not provide any concrete answers and merely adds to the body of opinion surrounding the right of a minor to consent to and refuse medical treatment.

5.21 The Commission has questioned the suitability of a criminal statute to safeguard the rights of children in the context of health care. Section 23 of the 1997 Act is not an adequate foundation to uphold the rights of the child to consent and refuse medical treatment, and the Commission has advocated legislative reform.¹⁷

5.22 In relation to the development of the common law in this area, outlined in chapter 4¹⁸, it is probable that the mature minor rule would be accepted by the Irish courts. The common law has recognised the capacity of minors to make certain decisions, and the law on capacity is moving away from the traditional status approach employed to determine the legal capacity of particular individuals.¹⁹ The Commission’s 1994 *Report on Non-Fatal Offences*

¹⁶ See discussion at 4.02.

¹⁷ At 4.117.

¹⁸ At 4.02.

¹⁹ See 4.121.

Against the Person stated that a minor is not incapable of giving an effective consent by reason of his or her minor status only.²⁰

5.23 Domestic jurisprudence on minors' refusal of medical treatment is limited, thus it is useful to draw on the experience of other countries where the issue has been addressed by legislation and case law. The Canadian courts in particular have dealt with the intersection of issues of age, autonomy, and self-determination in the context of refusal to medical treatment.

(2) Canada

5.24 The common law mature minor rule is established in Canada, and some of the different legal territories have also passed legislation on the subject. As mentioned in chapter 4²¹ the relationship between the mature minor rule and child welfare legislation has been debated in the courts, primarily in respect of refusal of essential medical treatment. If a mature minor makes a decision to which child welfare authorities object, the authorities may seek to override the mature minor's status of legal capacity and have the decision to refuse medical treatment quashed, on the basis that the child is in need of protection.²² The incorporation of the best interests principle in various statutory provisions means that mature minors will only have their decision to refuse medical treatment upheld if the decision is deemed to be in their best interests.

5.25 Several cases involving the refusal of blood transfusions by Jehovah's Witnesses have come before the courts, resulting in some interesting judgements on the relationship between the mature minor rule and child welfare legislation. A recent judgment of the Canadian Supreme Court in *AC v Manitoba*²³ concerning the refusal of a 14 year old girl of the administration of life sustaining blood transfusions provides a valuable analysis of the law concerning medical decision-making by a mature minor.

5.26 Arbella J, explaining the reasoning of the judgment, outlined the tension caused by respecting the autonomy of a child, whilst also trying to protect the interests and welfare of the child. A solution to this tension must

²⁰ Law Reform Commission *Report on Non-Fatal Offences Against the Person* (LRC 45-1994).

²¹ At 4.21.

²² See Ferguson *The end of An Age: Beyond Age Restrictions for Minors Medical Treatment Decisions* (Paper prepared for the Law Reform Commission of Canada 2004) at 8-21 for a detailed discussion of the relationship between health care consent legislation, the mature minor rule, child welfare legislation and the court's *parens patriae* jurisdiction.

²³ *A.C. v Manitoba (Director of Child and Family Services)*, 2009 SCC 30.

recognise the complexity of the situation²⁴. In the majority of situations concerning the medical treatment of a minor, his or her life will not be gravely endangered by the outcome of a particular decision. That is why the courts have determined that medical practitioners should be free to rely on the instructions of a young person who demonstrates sufficient maturity to make health care decisions. In cases however where medical treatment is needed to protect the life of a young person, the state retains an overreaching power to determine whether allowing the child to exercise his or her autonomy accords with his or her best interests. The case is discussed in detail in paragraph 5.51 below.

5.27 In the following paragraphs, the Commission examines the operation of the mature minor rule in the context of refusal of medical treatment in a number of Canadian states and territories.

(i) New Brunswick

5.28 The *Medical Consent of Minors Act 1976*, adopted from the Uniform Law Conference in 1975, grants people aged 16 years and older the right to consent to medical treatment as if they were of full age:

“The law respecting consent to medical treatment of persons who have attained the age of majority applies, in all respects to minors who have attained the age of sixteen years in the same manner as if they had attained the age of majority.”²⁵

5.29 This clearly suggests that a 16 year old can consent to and refuse medical treatment as if he or she were of full age. In relation to mature minors under the age of 16, their decision to refuse medical treatment is dependent on the practitioner’s assessment of the best interests of the patient:

“The consent to medical treatment of a minor who has not yet attained the age of sixteen years is as effective as it would be if he had attained the age of majority where, in the opinion of a legally qualified medical practitioner, dentist, nurse practitioner or nurse attending the minor,

- (a) The minor is capable of understanding the nature and consequences of a medical treatment and,

²⁴ See comments made by participants on Consultation Day at 1.60.

²⁵ Section 2 of the *Medical Consent of Minors Act 1976*.

- (b) The medical treatment and the procedure to be used is in the best interests of the minor and his continuing health and well-being.²⁶

5.30 The first case to raise issues requiring clarification in relation to the *Medical Consent of Minors Act 1976* came before the courts in 1994 in *Walker*, a case concerning the refusal of medical treatment by a 15 year old boy.²⁷ The boy was a Jehovah's Witness who objected to the administration of blood transfusions as part of recommended treatment for leukaemia. He did however consent to an alternative course of treatment. His treating doctors felt that he was sufficiently mature to understand the consequences of his refusal and were not prepared to administer the blood transfusions against the wishes of the mature minor.

5.31 In the Court of Queen's Bench, Turnbull J held that if the minor in question was likely to die without the treatment, the transfusions should be administered to him.²⁸ The New Brunswick Court of Appeal unanimously overturned the decision and declared that the boy was a mature minor under the provisions of the 1976 Act.

5.32 Hoyt C.J. stated that the trial judge proceeded under two misapprehensions. First, that the common law did not recognise that minors could be sufficiently mature to make decisions about their medical treatment and second, that the right to consent to medical treatment did not include the right to refuse medical treatment. Hoyt C.J. referring to the case of *Malette v Schulman 1990*²⁹ stated that the right of self-determination which underlies the doctrine of informed consent also encompasses the right to refuse medical treatment.³⁰

5.33 Although the five judges agreed on the outcome of the case, they disagreed on broader issues in relation to minors' refusal of medical treatment. Justice Ryan analysed the provisions of the 1976 Act and concluded that the theme of the Act was positive, not negative and does not in any form refer to refusal of medical treatment. The inclusion of the term 'continuing health and

²⁶ Section 3 (1) of the *Medical Consent of Minors Act 1976*. See discussion in Downie *Dying Justice: A Case for Decriminalizing Euthanasia and Assisted Suicide in Canada* (University of Toronto Press 2004) at 21.

²⁷ *Region 2 Hospital Corp v Walker* [1994] NBJ 174 (NBQB) rev'd [1994] NBJ 242 (NBCA).

²⁸ Turnbull J at paragraph 8.

²⁹ 72 OR (2d) 417 at 424.

³⁰ *Ibid* at 424.

well being' indicate situations where life is not threatened or at least a situation where there is a positive result from treatment.³¹ It seems that much was placed on the fact that the minor's prognosis, even with blood transfusions was poor and the treating doctors believed that forced treatment would serve to exacerbate his condition.³²

(ii) British Columbia

5.34 As mentioned earlier in chapter 4,³³ section 16 of the British Columbia *Infants Act 1973*³⁴ is comparable to section 25 of the New Zealand *Guardianship Act 1968*, section 8 of the UK *Family Law Reform Act 1969*, and section 23 of the *Non-Fatal Offences Against the Person Act 1997*.

5.35 *The Infants Act 1973* enables a young person of any age to consent to health care, provided the young person understands the nature and consequences of the health care and the care is, in the provider's opinion, in the best interests of the young person.³⁵ Therefore the consent or refusal of a minor is only sufficient where the health care provider considers the decision to be in the best interests of the minor.³⁶

5.36 The British Columbia Court of Appeal considered the mature minor rule and the *Infants Act 1996*³⁷ in the case of *Van Mol v Ashmore 1999*.³⁸ The case concerned a claim of negligence made against a doctor for failing to explain the risks involved in a surgical procedure to the claimant who was a 15 year old mature minor at the time of the operation. The court held that the

³¹ Ryan J at paragraph 53.

³² Ferguson *The end of An Age: Beyond Age Restrictions for Minors Medical Treatment Decisions* (Paper prepared for the Law Reform Commission of Canada 2004) at 32.

³³ At 4.05.

³⁴ Section 16 of the *Infants Act 1973* was amended by Section 16 of the *Infants Act 1992* and renumbered as Section 17 in the *Infants Act 1996* as part of the Statute Law Revision process in British Columbia.

³⁵ See paragraph 4.31.

³⁶ Downie *Dying Justice: A Case for Decriminalizing Euthanasia and Assisted Suicide in Canada* (University of Toronto Press 2004) at 22.

³⁷ Section 16 of the *Infants Act 1973* was amended by Section 16 of the *Infants Act 1992* and renumbered as Section 17 in the *Infants Act 1996* as part of the Statute Law Revision process in British Columbia. See 4.31.

³⁸ *Van Mol (Guardian ad Litem of) v Ashmore* [1999] BCJ No 31 (BCCA).

doctor had failed to reach the standard of informed consent. Although the case was not directly concerned with a minor's right to refuse medical treatment, Lambert J emphasised that when the required capacity to consent has been reached, decisions about undergoing treatment rest entirely with the mature minor:

“All rights in relation to giving or withholding consent will then be held entirely by the child.”³⁹

5.37 Lambert J also approved to the judgment of Hoyt CJ in *Walker*.⁴⁰ Huddart J, concurring, stated that there is nothing in the *Infants Act* to permit treatment when a competent minor refuses. Huddart J also referred briefly to the English case of *Re R*⁴¹, criticising the notion of concurrent rights of consent⁴² proposed by Lord Donaldson, discussed below at 5.82.

(iii) Alberta

5.38 The mature minor rule has been developed in Alberta, with the limitation that provincial child welfare legislation can displace the common law rule in that child welfare authorities can be granted the authority to consent to medical treatment, regardless of the maturity of the child in question.⁴³ In both cases discussed below, the court held that the mature minor rule can be overridden by child welfare legislation in the best interests of the child.

5.39 In the case of *C.U. (Next Friend of) v. Mc Gonigle 2003*⁴⁴ the Alberta Court of Appeal held that the mature minor rule does not apply in the context of child welfare legislation where a child is in need of protection, namely essential medical treatment.⁴⁵ The case concerned a 16 year old girl who was a Jehovah's

³⁹ Lambert J at paragraph 75.

⁴⁰ *Region 2 Hospital Corp v Walker* [1994] NBJ 174 (NBQB) rev'd [1994] NBJ 242 (NBCA).

⁴¹ [1991] 4 All ER 177.

⁴² Concurrent powers of consent –A minor is deemed sufficiently mature to consent to medical treatment, however his or her parents also retain a right of consent to medical treatment on behalf of the mature minor child.

⁴³ Downie *Canadian Health Law and Policy* (Lexis Nexis Canada 2007) at 442.

⁴⁴ *C.U. (Next Friend of) Mc Gonigle* [2000] AJ No 1067 (Alta Q.B.) aff'd [2003] ABCA 66 (Alta C.A.).

⁴⁵ *Child Welfare Act 1984-2000*. Note that the *Child Welfare Act 1984* was in force at the time as the *Child Welfare Act 2000*, and has since been replaced by the *Child Youth and Family Enhancement Act 2000*. Section 22(1) provides a director

Witness and refused to consent to the administration of blood transfusions as part of a surgical procedure. The Alberta Provincial Court granted the hospital a Treatment Order to administer the transfusions, which were carried out and the minor recovered fully from her illness. She appealed to the Alberta Court of Queen's Bench, arguing that she was a mature minor who should have been entitled to refuse medical treatment. Clarke J considered her maturity and held that she was in fact a mature minor, but concluded that maturity was not the key issue. In affirming the order of the Provincial Court, Clarke J held that the *Child Welfare Act 2000* was a complete and exclusive code for dealing with the issue, which superseded the common law doctrine.

5.40 The Court of Appeal, upholding the judgment of Clarke J, held that the mature minor rule does not apply in child welfare proceedings where a child refuses to consent to essential treatment recommended by a physician. While the court must consider the expressed wishes of a mature child, it is not bound to comply with those wishes. Instead, the best interests of the child govern. Russell J explained that in such a case, no one disputes that a mature minor can provide an informed consent to medical treatment, nor that a parent cannot overrule such consent:

“The parental right to determine whether or not a minor child will receive medical treatment terminates when the child achieves a sufficient understanding and intelligence to provide an informed consent.”⁴⁶

5.41 The appellant contended that the jurisdiction of both the courts and the legislature over minors derives from their *parens patriae* jurisdiction, which ends when a young person possess the capacity of a mature minor. Russell J, whilst accepting that such limitations may exist on the *parens patriae* jurisdiction of the court, did not accept such an argument in relation to the legislature's jurisdiction over children. The power of the legislature to enact provisions with respect to minors forms part of the legislature's general jurisdiction to enact laws affecting its subjects.

5.42 Russell J held that the approach of the legislature is consistent with society's historical interest in preserving the life and well-being of minors. While the court must consider the wishes of a mature child, it is not bound to comply with those wishes. The best interest of the child is the overriding concern and will be the final determinative:

under the Act with the authority to obtain medical treatment for an apprehended child if the child or the guardian cannot or will not consent to the treatment.

⁴⁶ Russell at paragraph 29.

“Further, it is consistent with Canada’s obligations under the UN Convention on the Rights of the Child to make the best interests of the child a primary consideration in decisions affecting children, while allowing a child capable of forming an opinion to express it, and the right for that opinion to be given due weight in accordance with the age and maturity of the child”⁴⁷

5.43 In 2002, a similar case came before the Court of Queen’s Bench, involving an assessment of the relationship between the mature minor rule and the *Child Welfare Act 1984*. The case involved a 16 year old girl who was a member of the Jehovah’s Witness faith and refused treatment involving blood transfusions.⁴⁸ One of the issues to be decided by the court was whether or not the patient, B.H. was a mature minor, a question which was answered in the affirmative. Kent J outlined the difficulty in dealing with ethical and moral issues raised by the decision of a mature minor to reject essential treatment.

“As we are all taught in first year law school, hard cases make bad law. In my view, a restrictive test for the mature minor principle is and ought to be the law. To require physicians, lawyers and judges to delve into cultural or religious beliefs to determine if the child is not only capable of making a decision but makes a good decision leads to uncertainty and the potential for unreasonable, ill-founded decisions.”⁴⁹

5.44 Applying this reasoning, Kent J disagreed with the finding of the trial judge that BH did not have the life or developmental experience to enable her to question her faith and was therefore not a mature minor. Although BH may not have analysed the situation in a way to lead her to the conclusion, held by the majority of society, that blood transfusions are acceptable - this does not mean that she is not a mature minor. What mature minor status requires is the intelligence to do the analysis, not that it has been done.⁵⁰

“to say that no Jehovah’s Witness child who is of sufficient intelligence and ability to understand the nature and consequences of proposed medical treatment can refuse blood because the refusal

⁴⁷ Russell J at paragraph 38.

⁴⁸ *B.H. (Next friend of) v. Alberta (Director of Child Welfare)* [2002] A.J. No.518 (Alta. QB) aff’d [2002] AJ No 568 (Alta CA).

⁴⁹ Kent J at paragraph 35.

⁵⁰ See discussion in Ferguson *The end of An Age: Beyond Age Restrictions for Minors Medical Treatment Decisions* (Paper prepared for the Law Reform Commission of Canada 2004) at 12.

comes from a religious conviction which we believe is wrong creates a principle which may be used at other times in dangerous circumstances.”⁵¹

5.45 Turning to the relationship between the mature minor rule and the *Child Welfare Act*, Kent J examined the provisions of the Act and held that it forms a complete and exclusive code for dealing with refusal of essential treatment. Kent J also considered the judgement in *Mc Gonigle*⁵² and agreed that the *Child Welfare Act 2000* replaces the common law principle of mature minor in so far as it relates to a child in need of protective services in the nature of essential medical treatment. Although the decision of a mature minor is final, in that it cannot be overridden by the child’s parents, the decision is not final in relation to the *parens patriae* jurisdiction of the court and the provisions of the *Child Welfare Act 2000*.

5.46 Thus the law in Alberta holds that where treatment which has been refused is deemed to be essential treatment required for the survival or well-being of the minor, the provisions of the *Child Welfare Act* apply. The common law principle of mature minor is therefore replaced by the Act in situations where medical treatment is essential and in the best interests of the minor.

5.47 The reasoning employed by the judgments discussed above has been seen as something of a means to an end, a response to the primary objective of ensuring that young people receive essential treatments and reach the age of majority in good health.⁵³ This is understandable indeed one can argue that a decision to refuse life sustaining treatment is not comparable to a decision to consent to treatment.

5.48 Mason, whilst accepting the logicity of the argument that there is no difference between capacity to consent and capacity to refuse; draws attention to the fact that while consent entails the acceptance of an experienced medical view, refusal entails the opposite.⁵⁴ In relation to a person under 18 years of age, such a decision is made from a standpoint of relatively limited understanding and experience. Furthermore, a refusal of treatment most likely involves closing down or removing future options, which may be regretted.

⁵¹ Kent J at paragraph 36.

⁵² See 5.39.

⁵³ Ferguson *The end of An Age: Beyond Age Restrictions for Minors Medical Treatment Decisions* (Paper prepared for the Law Reform Commission of Canada 2004) at 36.

⁵⁴ Mason & Mc Call Smith’s *Law and Medical Ethics* (7th ed Oxford University Press 2006) at 372.

5.49 As noted by Ferguson:

“The emphasis placed on physical well-being is understandable to the extent that it easily fits with the principles embodied within child welfare legislation than a more holistic approach... Consideration of physical health presents the issues to judges in a more manageable way than the potentially huge volume of conflicting views that might surround an investigation into matters such as the importance of religious beliefs to minors, or the enduring effects of emotional trauma.”⁵⁵

(iv) Manitoba

5.50 As discussed in chapter 4,⁵⁶ the Manitoba Law Reform Commission published a report in 1995 with a recommendation that the common law concept of maturity should be maintained to determine whether or not a young person has the power to make health care decisions.⁵⁷ The Commission did not believe that the mature minor rule should be put in legislative form due to a danger of anchoring the law into inflexible legislative language which may be insensitive to a variety of unforeseen future changes in society and medical practice. A legislative policy has developed in Manitoba, rejecting fixed rules in relation to medical decisions and promoting individualised assessments of capacity.⁵⁸ Binnie J, however, in a dissenting judgment discussed below, was of the opinion that the operation of child welfare legislation in relation to refusal of medical treatment by mature minors seems to be at variance with the approach of the Manitoba Law Reform Commission.

5.51 The recent case of *AC v Manitoba (Director of Child and Family Services) 2009*⁵⁹ involved a mature minor who was admitted to hospital at 14 years of age, suffering from internal bleeding. Some months before hospitalisation, she had signed an advance care directive refusing blood products on account of her religious beliefs. Her doctors stated that the bleeding

⁵⁵ Ferguson *The end of An Age: Beyond Age Restrictions for Minors Medical Treatment Decisions* (Paper prepared for the Law Reform Commission of Canada 2004) at 40. See also Gilmour “Children, Adolescents and Health Care” in Downie (ed) *Canadian Health Law and Policy* (2nd ed Butterworths 2002).

⁵⁶ At 4.41.

⁵⁷ Manitoba Law Reform Commission *Minors’ Consent to Health Care* (Report 91 1995).

⁵⁸ Day “The Capable Minor’s Healthcare: Who Decides?” (2007) 86(3) *Canadian Bar Review* 379 at 386.

⁵⁹ [2009] SCC 30.

caused an imminent serious risk to her health and perhaps her life. The minor understood the reason why a blood transfusion was recommended and the consequences of refusal. The Director of Child and Family Services apprehended her as a child in need of protection and sought a treatment order under Section 25(8) of the, which provides for the authorisation of treatment in the best interests of the child.⁶⁰ The treatment in question was granted by the Manitoba Court of Appeal. The minor and her parents appealed the order arguing that the legislation was unconstitutional and infringed her following rights under the Canadian Charter of Rights and Freedoms:

“2. Everyone has the following freedoms:

(a) Freedom of conscience and religion.

7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice. *Child and Family Services Act*

15. Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.”

5.52 The minor’s appeal was grounded on the fact that Section 25(9) of the *Child and Family Services Act* presumes that the best interests of a child aged 16 or over will be most effectively promoted by allowing the child’s views to be determinative, unless it can be shown that the child does not understand the decision or appreciate its consequences. Where the child is under 16, however, as in the present case, no such presumption exists.⁶¹ It was argued that this legislative scheme was unconstitutional because it unjustifiably

⁶⁰ Section 25(8) “Subject to subsection (9), upon completion of a hearing, the court may authorize a medical examination or any medical or dental treatment that the court considers to be in the best interests of the child.”

⁶¹ Section 25(9)” The court shall not make an order under subsection (8) with respect to a child who is 16 years of age or older without the child’s consent unless the court is satisfied that the child is unable

(a) To understand the information that is relevant to making a decision to consent or not consent to the medical examination or medical or dental treatment; or

(b) To appreciate the reasonably foreseeable consequences of making a decision to consent or not consent to the medical examination or the medical or dental treatment.

infringed the rights of the minor under sections 2(a), 7 and 15 of the *Canadian Charter of Rights and Freedoms*.

5.53 The appeal was dismissed by a 6:1 majority. The court held that when a young person's best interests are interpreted in a way that sufficiently respects his or her capacity for mature, independent judgement in a particular medical-decision making context, the constitutionality of the legislation is preserved. The statutory scheme is constructed in such a way to take an adolescent's maturity into account and therefore strikes a constitutional balance between what the law has consistently seen as an individual's fundamental right to autonomous decision making in connection with his or her body, and the law's equally persistent attempts to protect vulnerable children from harm.

5.54 Abella J, referring to the best interest standard in section 25(8) as the conceptual cornerstone of the Act,⁶² stated that an interpretation of best interest must take into account the maturity of a particular adolescent in any given medical treatment context:

“It is a sliding scale of scrutiny, with the adolescent's views becoming increasingly determinative depending on his or her ability to exercise mature, independent judgement. The more serious the nature of the decision, and the more severe its potential impact on the life or health of the child, the greater the degree of scrutiny that will be required.”⁶³

5.55 Furthermore, such an interpretation of best interests is conceptually consistent with the evolutionary development of the common law mature minor doctrine in both Canadian and international jurisprudence. The courts have, by way of the mature minor doctrine, accepted that an adolescent's treatment wishes should be granted a degree of deference that is reflective of his or her evolving maturity. Rarely, however, have they viewed this mandate as being inconsistent with their overarching responsibility to protect children from harm.

5.56 Abella J stressed that cases such as the present one before the court, are rare. In the vast majority of cases concerning the medical treatment of a minor, his or her life will not be gravely endangered by the outcome of any particular treatment decision. Medical practitioners therefore are generally free to rely on the decision and instructions of a mature minor. Where a minor however comes before the courts under section 25, it means that child protection services have concluded that medical treatment is necessary to protect his or her life. In such rare cases, it is the inherent difficulty in assessing a minor's maturity to make such a vital decision which justifies the state's intervention, and the court's scrutiny of whether the decision accords with the

⁶² Abella J at paragraph 32.

⁶³ Abella J at paragraph 22.

best interests of the child. The degree of scrutiny will naturally be most intense in cases where a medical decision is likely to endanger a child's life.

5.57 There may be cases however, where the courts are so convinced of a child's maturity that the principles of welfare and autonomy collapse and the child's wishes become the controlling factor:

"If, after a careful and sophisticated analysis of the young person's ability to exercise mature, independent judgement, the court is persuaded that the necessary level of maturity exists, it seems to me necessarily to follow that the adolescent's views ought to be respected."⁶⁴

5.58 Abella J set out a number of guiding factors to be considered in the assessment of a minor's maturity as set out in Chapter 4 at 4.25.

5.59 Mc Lachlin CJ stated that the *Child and Family Services Act* provides a comprehensive statutory scheme which displaces the existing common law regarding medical decision-making by mature minors. Although the mature minor doctrine remains the applicable law with respect to capable adolescents' consent to medical treatment, the Manitoba legislature has addressed the specific child welfare concerns that arise where necessary care is refused. The state has an interest in ensuring that children receive necessary medical care.

5.60 The legislative decision to vest treatment authority regarding minors under 16 in the courts is a legitimate response to heightened concerns about the maturity of younger adolescents. The concern with free and informed decision-making animates the legislative scheme and expresses the State's interest in ensuring that momentous decisions to refuse medical treatment by persons under 16 are truly free, informed and voluntary.⁶⁵ The legislature's decision not to accord a presumption of consent to children under 16 reflects the reality that the judgement capabilities of children in relation to momentous personal decisions increases with age.

5.61 Binnie J, dissenting, stated at the outset that forced medical procedures must be one of the most egregious violations of a person's physical and psychological integrity. Whilst it is understandable that judges would instinctively give priority to the sanctity of life, the rejection of potentially lifesaving effects of blood transfusions by Jehovah's Witnesses is fundamental to their religious convictions.⁶⁶

⁶⁴ Abella J at paragraph 87.

⁶⁵ McLachlin C.J. at paragraph 143.

⁶⁶ Binnie J at paragraphs 167 & 191.

5.62 Binnie J referred to the Supreme Court case of *Starson v Swayze 2003*,⁶⁷ where the Court held that a best interest assessment is only appropriate in the absence of an individual's capacity to decide for him or herself.

5.63 It may be assumed that children generally lack the requisite degree of capacity and maturity to make potentially life-defining decisions. It is precisely the lack of capacity and maturity, however, which provides the state with a legitimate role in taking the decision-making power away from the young person and vesting it in a judge. The legitimate basis of state intervention in the life of a young person however ceases to exist with a judicial finding of maturity in the case of a particular minor.

5.64 The purpose of the *Child and Family Services Act* is to defend the best interests of children who are in need of protection, which in the present context, means children who do not have the capacity to make their own decisions regarding medical treatment. The state's interest in ensuring judicial control over the medical treatment of minors ceases to exist where a mature minor under 16 demonstrates the lack of need for any such overriding state control.

5.65 Although a minor is, theoretically, given the opportunity to rebut the presumption under section 25, it seems that in practice, the capacity of a minor is accepted without question yet his or her refusal is overridden, regardless of capacity. Binnie J found section 25 of the *Child and Family Services Act* to be unconstitutional because it prevents a person under 16 years of age from establishing that he or she understands the consequences of refusing treatment and therefore has the right to refuse treatment; regardless of whether or not a judge considers such refusal to be in the person's best interests.

5.66 Referring to the *Van Mol*⁶⁸ case:

"The young person with capacity is entitled to make the treatment decision, not just to have 'input' into a judge's consideration of what the judge believes to be the young person's best interests.....The fact that in the end a judge disagrees with the mature minor's decision is not itself a lawful reason to override it."⁶⁹

5.67 As strong as society's belief is in the sanctity of life, it is equally fundamental that every competent individual is entitled to autonomy to choose to consent or refuse medical treatment, except as that autonomy may be limited within the framework of the Constitution.

⁶⁷ [2003]1 SCR 722, [2003] SCC 32.

⁶⁸ *Van Mol v Ashmore* [1999] BCJ No 31 (BCCA).

⁶⁹ Binnie J at paragraphs 202 and 175 .

5.68 Binnie J concluded that the *Child and Family Services Act* had modified the mature minor rule, in that the decisions of mature minors would only be respected where the minor was 16 years of age and over. The question to be answered therefore was whether or not the modified mature minor rule is compliant with the provisions of the Canadian Charter of Rights and Freedoms. Binnie J answered this in the negative.

5.69 The clear and detailed analysis by the Canadian Supreme Court in this case has greatly added to the body of jurisprudence on the rights and decision-making capacities of mature minors. In sum, the court upheld the constitutionality of section 25(8), stating that it was a proportionate response to the goal of protecting vulnerable young people from harm, while respecting the individuality and autonomy of those who are sufficiently mature to make a particular treatment decision.

(v) Ontario

5.70 Section 2(2) of the *Substitute Decisions Act 1992* established a presumption that people aged 16 years and over are capable of giving or refusing consent in respect of their own personal care.⁷⁰ *The Consent to Treatment Act 1992*, replaced by the *Health Care Consent Act 1996*, was enacted to codify the law relating to consent to medical treatment and established rules and procedures for administering health care to incapable persons. Section 4(2) creates a general presumption that a person is capable of making decisions about treatment, admission to a care facility and personal assistance services. The test for capability is set out in section 4(1):

“A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.”⁷¹

5.71 It seems therefore that mature minors have a statutory right to refuse treatment, regardless of whether the courts or the health care provider

⁷⁰ Section 2(2) “A person who is 16 years of age or more is presumed to be capable of giving or refusing consent in connection with his or her own personal care.

⁷¹ The Canadian Supreme Court has stated that the test for capacity is not limited to a lack of rational ability to understand, but extends to a lack of ability to appreciate or judge the situation. *Starson v Swayze* [2003] 1 S.C.R. 722 [2003] SCC 32.

considers it to be in the minor's best interests⁷². The evaluation of capability will be made by the health care practitioner and there is also a method of review available whereby those deemed incapable can apply to the Consent and Capacity Board for a review of the assessment. Given the presumption of capacity in section 4(1) it is unclear how child welfare legislation, namely the *Child and Family Services Act 1990*⁷³, will impact on the legal capacity of a mature minor to refuse medical treatment.

5.72 Before the enactment of the health care consent legislation, in 1985, the Ontario Provisional Court upheld the decision of a 12 year old mature minor to refuse medical treatment, on religious grounds.⁷⁴ Justice Main stated that she had been discriminated against on the basis of her religion and her age and the emotional trauma caused by the forced administration of blood transfusions would outweigh the intended benefits of the treatment.

5.73 At first glance the case seems like something of a departure from the majority of cases involving a mature minor and refusal of medical treatment however the basis of the decision was that the treatment was not in the best interest of the minor. The odds of a favourable outcome after treatment were rather low, at 30 percent, and the side effects were severe.

(vi) Prince Edward Island

5.74 The *Consent to Treatment and Health Care Directives Act 1988* states that:

“Every patient who is capable of giving or refusing consent to treatment has the right

- (a) to give consent or to refuse consent on any grounds, including moral or religious grounds, even if the refusal will result in death;
- (b) to select a particular form of treatment from among those proposed by a health practitioner on any grounds, including moral or religious grounds;
- (c) to be assisted by an associate; and

⁷² Downie *Dying Justice: A Case for Decriminalizing Euthanasia and Assisted Suicide in Canada* (University of Toronto Press 2004) at 21.

⁷³ Section 37(2) “A child is in need of protection where.....(e) the child requires medical treatment to cure, prevent or alleviate physical harm or suffering and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable to consent to, the treatment”

⁷⁴ *Re L.D.K.* (1985) 48 R.F.L. (2d) 164 (Ont. Prov Ct).

(d) to be involved to the greatest degree practicable in case planning and decision making.”⁷⁵

5.75 Capacity is assessed by a health care practitioner according to the patient’s ability to understand the information that is relevant to making a decision concerning the treatment, to understand the information that applies to his or her particular situation, to understand his or her right to make a decision; and appreciate the reasonably foreseeable consequences of a decision or lack of decision.⁷⁶

(vii) Quebec

5.76 The Civil Code states that parental consent is necessary for a person under 14 years of age in respect of treatment “required by the state of health” of the young person.⁷⁷ Young people aged 14 years or older can give their own consent or refusal but their refusal may be overridden by court authorisation. For treatment “not required by the state of health” of the young person, those aged under 14 years of age cannot consent. Young people aged 14 years or older can consent unless it involves a serious risk to the young person’s health or may result in grave and permanent effects (in which case parental consent is required).

5.77 The Civil Code also states that the court may authorize treatment in cases where a minor aged 14 years of age or older refuses medical treatment.⁷⁸ Article 14 (1) provides that consent to care required by the state of health of a minor is given by the person having parental authority or his tutor. It seems that parental support will largely determine whether or not a minor’s decision to refuse treatment will be upheld.⁷⁹ The law in Quebec therefore, in relation to adolescent autonomy and refusal of medical treatment, is not as wide ranging as the other Canadian provinces which follow the mature minor rule.

(3) England

5.78 The issue of minor’s consent to and refusal of treatment has generated much case law in England, resulting in a range of judgments to

⁷⁵ Section 4 of the *Consent to Treatment and Health Care Directives Act*.

⁷⁶ *Consent to Treatment and Health Care Directives Act 1988*.

⁷⁷ Civil Code, RSQ 1991, c. C-1991 (Quebec) art 14, 16, 17, 18.

⁷⁸ Civil Code, RSQ 1991, c. C-1991 (Quebec) art 16, 23.

⁷⁹ Ferguson *The End of An Age: Beyond Age Restrictions for Minors Medical Treatment Decisions* (Paper prepared for the Law Reform Commission of Canada 2004) at 26.

clarify the relationship between minors, parents, health care practitioners and the courts. As already discussed in Chapter 3 in the *Gillick* case⁸⁰ the House of Lords held that that a minor's capacity to consent to medical treatment should be assessed on the basis of maturity and understanding, rather than age alone.

5.79 Following the decision in *Gillick* various legislative provisions dealing with diagnosis and treatment of children were amended to recognise the legal capacity of a mature minor to consent to and refuse treatment. The *Children Act 1989* contains five provisions which give a child (of sufficient understanding to make an informed decision) the power to refuse to submit to medical and psychiatric examinations and other assessments.⁸¹ The 1989 Act is silent on the rights of minors to make treatment decisions independently of those with parental responsibility for them but has been interpreted as approving the *Gillick* case and conferring a power of veto upon the competent child.⁸² However, when faced with cases of refusal of treatment, courts have struggled to respect the decision of the mature minor patient.

5.80 It has been suggested by some commentators that this involves a retreat from *Gillick* and the *Children Act 1989*, and has created a precedent that mature minors cannot refuse treatment. This has been criticised as inconsistent with the fundamental principle of consent by setting a higher tariff for refusing a medical examination or procedure than for consenting to one.⁸³

5.81 The relationship between the provisions of the *Children Act 1989* and the inherent jurisdiction of the court was revealed in a case concerning a mature minor's refusal to submit to a psychiatric examination, under section 38(6) of the 1989 Act.⁸⁴ It was argued that where a minor has a statutory right to refuse to submit to an examination, the court cannot override the minor's decision. This argument was not accepted. Douglas Brown J held that the 1989 Act had preserved the inherent jurisdiction of the High Court with respect to children and

⁸⁰ *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 All ER 402. See 3.83.

⁸¹ S.38(6), s.43(8), s.44(7) and paragraphs 4(4)(a) and s.5(a) of Schedule 3 of the *Children Act 1989*. See Brazier and Bridge "Coercion or caring: analysing adolescent autonomy" (1996) 16 *Legal Studies* 84 at 96.

⁸² Freeman, "Rethinking Gillick" (2005) 13 *International Journal of Children's Rights* 201 at 204.

⁸³ Devereux et al "Can Children withhold consent to treatment?" (1993) *BMJ* 1459 at 1460.

⁸⁴ *South Glamorgan County Council v W and B* [1993] 1 FLR 574.

the court could exercise that power in order to protect the welfare of the child. The application to remove the minor from her home and place her in a mental health unit was granted. It seems clear that the minor in question was suffering from a form of mental illness however there was a marked reluctance to make an application under the *Mental Health Act 1983*.⁸⁵

(i) Re R and Re W

5.82 *Re R*⁸⁶ involved a 15 year old girl who had voluntarily entered the care of a local authority and was known as a possible victim of emotional abuse. She was placed in an adolescent psychiatric care unit and refused to take anti-psychotic drugs. Her behaviour was disturbed and her capacity fluctuated but during lucid periods she was capable of understanding the nature and effect of the medication. The local authority initially gave permission for the administration of drugs but withdrew its consent on the basis that R was competent to express her own opinions and it was reluctant to authorise the administration of drugs against her will. The local authority then began wardship proceedings seeking permission to administer medication. The English Court of Appeal held that the *Gillick* test had no application in wardship cases. Even if the minor was considered *Gillick* competent, her refusal or consent could be overridden by a court in her best interests. Lord Donaldson likened consent to a key and held that the refusal by a *Gillick* competent child to consent to treatment did not prevent the necessary consent being obtained by another source, that is, another key holder, namely her parents or the court.

5.83 *Re W*⁸⁷ involved the refusal by a 16 year old to consent to treatment for anorexia. Lord Donaldson introduced a new analogy on the basis that keys could lock as well as unlock and a minor cannot lock the door to treatment. The new analogy was based on viewing consent as a flak jacket, to protect doctors from prosecution:

“Anyone who gives him a flak jacket may take it back, but the doctor only needs one and as long as he continues to have one he has the legal right to proceed.”⁸⁸

5.84 Both analogies have been criticised as reducing consent to a mere formality, designed to protect doctors from litigation.⁸⁹ Lord Donaldson alluded

⁸⁵ See discussion in Brazier and Bridge “Coercion or caring: analysing adolescent autonomy” (1996) 16 *Legal Studies* 84 at 97-101.

⁸⁶ *Re R (a minor) (wardship: consent to medical treatment)* [1991] 4 All ER 177.

⁸⁷ *Re W (a minor) (medical treatment: court’s jurisdiction)* [1992] 4 All ER 627.

⁸⁸ *Ibid* at 635.

to two reasons for the requirement of consent – a clinical reason, namely to make treatment easier and a legal reason, to defend health care practitioners from civil or criminal claims. It has been argued that this is an extremely narrow view of the principle of informed consent, one which applies the principle of informed consent to mature minors in order to protect doctors, rather than applying the principle to mature minors in order to respect their personal rights.

“The inconsistent adherence to the principle of self-determination is obvious, and, without the right to refuse, the right to consent seems devoid of any real import”⁹⁰

5.85 *Re W* is particularly significant because the minor at the centre of the dispute was 16 years old and could rely on section 8 of the *Family Law Reform Act 1969*⁹¹. The court held that although a 16 year old acquires a statutory right to consent to treatment under the 1969 Act, parental rights to authorise treatment co-exist with the rights of the minor.

5.86 The three judges in the English Court of Appeal stressed that although parental consent to treat a minor patient legally authorises a doctor to override the refusal of the minor patient, the wishes of the minor patient must be taken into account and accorded significant weight. Lord Donaldson stated that refusal by a minor was a very important consideration and its importance increases with age and maturity. Despite this, the decision in *Re W* provides that a competent minor cannot object to treatment which has been authorised by a parent until his or her 18th birthday.⁹²

5.87 In response to the criticism of the judgments in *Re R* and *Re W*, the Commission accepts that both patients involved suffered from an illness which greatly affected their judgement and capacity to make a choice. Lord Donaldson distinguished *W* from other adolescents because of her condition, which destroyed her ability to make an informed choice. The decisions made by the minors in *Re R* and *Re W* came before the courts because of a reluctance to

⁸⁹ Eekelaar “White Coats or Flak Jackets? Doctors, Children and the Courts-Again” (1993) 109 *Law Quarterly Review* 182 at 185.

⁹⁰ Huxtable “Re M (Medical Treatment: Consent) Time to remove the ‘flak jacket?’” (2000) 12(1) *Child and Family Law Quarterly* 83 at 84.

⁹¹ See discussion of Section 8 of the *Family Law Reform Act 1969* at 4.55.

⁹² Eekelaar “White Coats or Flak Jackets? Doctors, Children and the Courts-Again” (1993) 109 *Law Quarterly Review* 182 at 182, Thornton “Multiple Keyholders- Wardship and Consent to Medical Treatment” (1992) 51 *Cambridge Law Journal* 34 at 36.

use the Mental Health Acts and a desire to avoid stigma. Lord Donaldson stated:

“Although mental illness should not be regarded as any different from physical illness, it is not always so viewed by the uninformed and the fact that later in life it might become known that a minor had been treated under the Acts might rebound to his or her disadvantage⁹³”

5.88 The lack of capacity displayed by R and W was not due to their age however their minority status facilitated the avoidance of mental health legislation in favour of child welfare legislation.⁹⁴ The *Mental Health Act 1983* is applicable to people of all ages and contains safeguards for people deprived of their right to refuse, such as the requirement for a second opinion, time-limited application and opportunity for independent review.⁹⁵

5.89 It is unfortunate that the issue of refusal by a minor patient came before the courts in such a way, as issues of legal capacity have been equated with mental capacity, leading to confusion and the creation of uncertain precedents. Brazier and Bridge have analysed the cases of a minor’s refusal to treatment in conjunction with the definition of ‘mental disability’ used by the English Law Commission:

“any disability or disorder of the mind or brain, whether permanent or temporary, which results in an impairment or disturbance of mental functioning”⁹⁶

5.90 They are of the opinion that in the majority of cases of adolescent refusal of treatment coming before the courts, such mental disability is present. Once the fear of stigmatisation and mental illness is overcome such cases could be resolved without relying on an outcome test to assess capacity.

⁹³ Lord Donaldson at 642.

⁹⁴ Brazier and Bridge “Coercion or caring: analysing adolescent autonomy” (1996) 16 *Legal Studies* 84 at 96.

⁹⁵ *Mental Health Act 1983*, as amended by the *Mental Health Act 2007*. See Shaw “When Young People Refuse Treatment: Balancing Autonomy and Protection” in Rt Hon Lord Justice Thorpe & Cowton (eds) *Delight and Dole: The Children Act 10 Years On* (Jordan Publishing Bristol, 2002) at 49.

⁹⁶ Section 2 of the *Mental Capacity Act 2005* “a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain... It does not matter if the impairment or disturbance is permanent or temporary”

5.91 It is interesting to note that the interpretation of the mature minor rule to cater for concurrent powers of consent as set out in *Re R* and *Re W* has not been followed in Canada. In the 1993 *Ney* case, discussed above at 4.31, Huddart J referred to the principle set out by Lord Scarman in *Gillick* that the parental rights to consent to medical treatment on behalf of their children exist only when the child is incapable of granting or refusing consent.⁹⁷ Some years later in the British Columbia Court of Appeal,⁹⁸ Huddart J reiterated her agreement with the mature minor rule as set out in *Gillick* and her dissatisfaction with Lord Donaldson's proposed modification of the rule in *Re R*. In relation to the *Infants Act 1996*, Huddart J found nothing in the relevant provisions which would permit treatment when a competent infant of any age refuses, or to permit a medical practitioner to avoid facing the issue of refusal by seeking only the consent of the patient's parents.⁹⁹

5.92 The recent judgment by the Canadian Supreme Court confirmed this position with Abella J referring to the criticism of Lord Donaldson's judgment in *Re R* and *Re W*.¹⁰⁰ The High Court of Australia has also referred to the criticism of Lord Donaldson's approach to the issue of refusal by a mature minor and expressed concern over the rationale behind the judgment in *Re R*.¹⁰¹

(ii) *Re M*

5.93 The case of *Re M*¹⁰² concerned a 15 year old girl who, without a heart transplant, would die within a week. She refused the treatment and was completely opposed to the transplant:

"I would feel different with someone else's heart, that's a good enough reason not to have the heart transplant, even if it saved my life....I don't want to die but I would rather die than have the transplant and have someone else's heart"¹⁰³

5.94 M had discussed her refusal with her mother, her doctors and hospital staff and there was no suggestion that she did not satisfy the mature minor criteria as set out in *Gillick*.

⁹⁷ Huddart J at paragraph 146.

⁹⁸ *Van Mol v Ashmore* [1999] BCJ No 31 (BCCA) at para 143.

⁹⁹ *Ibid* at 145.

¹⁰⁰ *A.C. v Manitoba (Director of Child and Family Services)*, 2009 SCC 30 at para 54.

¹⁰¹ See discussion at 5.121.

¹⁰² *Re M (Medical Treatment)* FLR [1999] 2 FLR 1097.

¹⁰³ *Ibid* at 1100.

5.95 Johnson J stated that M was an intelligent girl whose wishes could carry considerable weight and stated that the imposition of a heart transplant on a young woman who objects is very serious indeed. He also referred to the consequences of his decision which M would have to live with:

“There are risks attached to the operation itself and there are continuing risks thereafter, both in terms of rejection in the medical sense and rejection by M of the continuing treatment. There is the risk too that she will carry with her for the rest of her life resentment about what has been done to her.”¹⁰⁴

5.96 Johnson J went on to authorise the transplant stating that events had overwhelmed M and the treatment was in her best interests:

“While I was very conscious of the great gravity of the decision I was making in overriding M’s wish, it seemed to me that seeking to achieve what was best for her required me on balance to give the authority that was asked.”¹⁰⁵

5.97 The instinct to preserve life in such an instance is obvious and, as discussed above, one can argue that a higher degree of competence is required in such decisions of life and death. These difficult situations however are the very cases in which it is vital for the patient in question to have a voice.¹⁰⁶ It is notable that Johnson J did not simply state that M was incompetent and therefore could not refuse the treatment in question. Rather, he stated that the authorisation of the treatment was in her best interests.

(iii) Re E, Re S, Re L and Re P

5.98 The courts have also dealt with minor patients who refuse treatment on religious grounds. In *Re E* a 15 year old Jehovah’s Witness with leukaemia refused the administration of blood products.¹⁰⁷ His parents also refused and the hospital began wardship proceedings to seek the court’s permission for treatment. Ward J found that E was a person of sufficient intelligence to make decisions about his well being and spoke intelligently and calmly about the consequences of his refusal. Despite this, he was not deemed to be *Gillick*

¹⁰⁴ *Re M (Medical Treatment)* FLR [1999] 2 1097,1100.

¹⁰⁵ *Ibid* at 1101.

¹⁰⁶ Huxtable “Re M (Medical Treatment: Consent) Time to remove the ‘flak jacket?’” (2000) 12(1) *Child and Family Law Quarterly* 83 at 87.

¹⁰⁷ *Re E (a minor) (wardship: medical treatment)* [1993] 1 FLR 386.

competent.¹⁰⁸ Moreover, if he was competent, his refusal would not have been binding on the basis that the court would decide the case on welfare grounds. E died two years later, upon reaching the age of majority and exercising his right to refuse treatment. A point to note in relation to the decision in *Re E* that Ward J found that the minor's decision was overly influenced by his religious upbringing, however Eekelaar has commented that if one is to hold a person incompetent because his decision reflects socially tolerated values ingrained in his upbringing, competence could hardly be achieved by anyone.¹⁰⁹

5.99 The cases of *Re S* and *Re L* involved two girls aged 15 and 14 who were also Jehovah's Witnesses, whose refusals to blood transfusions were similarly overridden by the courts.¹¹⁰ *Re S* concerned a 15 year old girl who was a new convert to the Jehovah's Witness faith who rejected blood transfusions and prayed for a miracle. Johnson J stated that S was not competent to make such a decision and seemed to equate her prayer for a miracle as immaturity, despite evidence from a psychiatrist who doubted whether she was seriously immature. The minor in the case of *Re L* was 14 years of age. She strongly opposed the proposed treatment and carried an advance medical directive stating that she did not wish to receive blood. The court authorised the treatment, stating that L had not been given all the details in relation to the nature of her death, if the treatment was not administered. Without the necessary information, L was denied the opportunity to make an informed choice yet her decision was analysed and deemed to be that of an incompetent person. As noted by Freeman:

"Combine an unwillingness to accept a child is Gillick-competent with a refusal to provide them with information....it becomes relatively easy to override an adolescent's refusal of treatment"¹¹¹

5.100 In 2004, the courts again authorised the administration of blood treatments to an adolescent who was of the Jehovah's Witness faith.¹¹² P was

¹⁰⁸ *Re E* was decided before *Re R* and *Re W* so the relevant authority was the *Gillick* case.

¹⁰⁹ Eekelaar "The Interests of the Child and the Child's Wishes: The Role of Dynamic Self-Determinism" (1994) 8(1) *International Journal of Law Policy and The Family* 42 at 57.

¹¹⁰ *Re S (a minor) (medical treatment)* [1994] 2 FLR 1065, *Re L (medical treatment: Gillick competency)* [1998] 2 FLR 810.

¹¹¹ Freeman, "Rethinking Gillick" (2005) 13 *International Journal of Children's Rights* 201 at 210.

¹¹² *Re P* [2004] 2 FLR 1117.

almost 17 years of age and objected to the proposed treatment. In reaching his decision, Johnson J alluded to the fact that P was almost 18 and seemed to envisage a similar fate to that of the adolescent in *Re E*:

“A court will have to consider whether to override the wishes of a child approaching the age of maturity when the likelihood is that all that will be achieved will have been deferment of an inevitable death and for a matter only of months”¹¹³

5.101 Despite the presence of weighty and compelling reasons to respect P’s refusal the treatment was authorised in P’s best interests “whatever they may be” - a rather vague statement which does not include any analysis of the complex relationship between P’s personal rights and his competency to refuse the proposed treatment.¹¹⁴

5.102 These cases have invoked criticisms for implying that the religious beliefs of adolescents lack the validity of adult faith. The requirements for assessing an adult’s competence to refuse treatment are much less stringent than those used for a minor and the predictable finding of incompetency has been criticised as an easy way out.¹¹⁵

“It is now the case that a child patient whose competence is in doubt will be found rational if he or she accepts the proposal to treat but may be found incompetent if he or she disagrees.”¹¹⁶

5.103 Bearing in mind that the issue of competency was not raised in *Re P*, it seems that the instinctive desire to preserve life takes precedence over any discussion of competency and autonomy.

5.104 *R (Axon) v Secretary of State for Health* has signalled a renewed focus on the autonomy of children and casts a shadow of doubt on the apparently settled retreat from Gillick.¹¹⁷ The circumstances, which have already been outlined in Chapter 3¹¹⁸ were similar to those in *Gillick* and concerned a

¹¹³ *Ibid* at 1119.

¹¹⁴ Freeman, “Rethinking Gillick” (2005) 13 *International Journal of Children’s Rights* 201 at 211.

¹¹⁵ *Ibid* at 209.

¹¹⁶ Devereux et al “Can Children withhold consent to treatment?” (1993) *BMJ* 1459 at 1459.

¹¹⁷ *R. (Axon) v Secretary of State for Health* [2006] 1 FCR 175, Herring *Family Law* (3rd ed Pearson Longman 2007) at 427.

¹¹⁸ At 3.95.

challenge by Mrs Axon as to the duty of confidentiality owed to children seeking advice on sexual matters, including abortion. In the English High Court Silber J relied on the *Gillick* case and ruled against the plaintiff on all grounds.

5.105 Silber J stressed the importance of the Convention on the Rights of the Child and the judgment is seen as a positive reinforcement of the importance of the rights of children in general, which may signal a growing respect for the autonomy of adolescents.

5.106 In relation to refusal of treatment Silber J stated:

“the parental right to determine whether a young person will have medical treatment terminates if and when the young person achieves a sufficient understanding and intelligence to understand fully what is proposed”

5.107 Herring sees this statement as an implication that if a child is competent, a parent has no right to determine what treatment a child will receive. This is a single obiter statement and cannot be taken as indicative of the law however it can be viewed as an indication of judicial unease with the way the law has developed, particularly in relation to the recent judicial statements made by the courts in Canada.¹¹⁹

5.108 In 2008, there was considerable attention in the English media surrounding a 13 year old girl, Hannah Jones.¹²⁰ She initially refused to consent to a heart transplant and was supported by her parents in her decision. The relevant health authority considered taking court proceedings to secure a determination of the validity of her decision-making. Following an interview with Hannah, however, the authority decided not to proceed with court proceedings and accepted her refusal. Months later, Hannah changed her mind and decided that a heart transplant would improve her quality of life. Her parents reiterated that they had left the decision up to her but were delighted she had reconsidered. It is important to note that this case did not involve any legal action and there was no definitive determination as to Hannah Jones’s decision-making capacity.

5.109 Developments in mental health legislation in the UK, discussed further in chapter 6,¹²¹ indicate an acceptance of a minor’s legal ability to refuse medical treatment. Following amendments made by the *Mental Health Act 2007*

¹¹⁹ Herring *Family Law* (3rd ed, Pearson Longman 2007) at 428.

¹²⁰ Irish Times “Teenage Girl in Britain wins Right to Die” 11/11/2008, The Guardian “Hannah’s Choice” 12/11/2008, The Guardian “Right-to-die teenager Hannah Jones changes mind about heart transplant” 21/07/2009.

¹²¹ At 6.57.

to the *Mental Health Act 1983* (the principal English legislation in this area),¹²² 16 and 17 year olds who have capacity under the *Mental Capacity Act 2005* (which deals with mental capacity generally)¹²³ may consent and refuse informal admission to a mental health care (psychiatric hospital) even where one or more persons may have parental responsibility for them. If the adolescent in question has capacity but does not consent to admission, he or she cannot be admitted by the consent of someone with parental responsibility. Consideration is given to whether the patient satisfies the criteria for formal detention. If the criteria are not satisfied, but treatment is considered to be in the patient's best interests, it may be necessary to seek court authorisation. The key point here is that when a 16 or 17 year old with capacity does not consent to informal admission, the consent of his or her parent cannot simply be used as substitute consent to detain the young person.

5.110 Children who are under 16 and *Gillick* competent may consent to informal admission, and additional consent from a person with parental responsibility is not required. In relation to refusal, the legal position remains rather unclear. The 2008 revised statutory Code of Practice on the Mental Health Act 1983 which takes account of the amendments made in 2007, refers to the autonomy of the competent child. Having regard to these changes, and even in the absence of case law which would also be required to take account of the UK Human Rights Act 1998¹²⁴ (under which courts must take into account the European Convention on Human Rights), the Code states that it may be unwise to rely on the consent of the person with parental responsibility.¹²⁵ Again, consideration should be given to whether the child meets the criteria for formal admission and detention under the Mental Health Act. If not, it may be appropriate to seek court authorisation.

5.111 In essence, the amended English mental health legislation no longer accepts that the consent of a parent may override the refusal of a child or adolescent with capacity. The child or adolescent can refuse treatment, with an option to seek direction from the court, acting as the ultimate guardian of the child in his or her best interests.

¹²² The comparable legislation in Ireland is the *Mental Health Act 2001*.

¹²³ The Government's *Scheme of a Mental Capacity Bill 2008*, which would largely implement the Commission's *Report on Vulnerable Adults and the Law* (LRC 83-2006), proposes to put in place a comparable legislative framework in Ireland.

¹²⁴ The comparable legislation in Ireland is the *European Convention on Human Rights Act 2003*.

¹²⁵ Department of Health Code of Practice Mental Health Act 1983 (London TSO 2008) at 36.43.

(4) Scotland

Scottish law is based on the mature minor common law position, complemented by legislative measures. Scottish law provides that parental responsibilities and rights end at 16, although the responsibility to provide guidance ends only at a child's 18th birthday.¹²⁶ *The Age of Legal Capacity (Scotland) Act 1991* gives young people full legal capacity to enter into most transactions at the age of 16.¹²⁷ Consequently, it can be argued that 16 year olds have the legal capacity to consent to and refuse treatment. In relation to young people under the age of 16, section 2(4) of the *Age of Legal Capacity (Scotland) Act 1991* states:

“A person under the age of sixteen shall have legal capacity to consent on his own behalf to any surgical, medical or dental procedure or treatment where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences”

5.112 Similar to section 8 of the UK *Family Law Reform Act 1969* and section 23 of the *Non-Fatal Offences Against the Person Act 1997* section 2 (4) of the 1991 Act does not refer to refusal.

5.113 Neither does section 2(4) contain any reference to the best interests of the child. The Scottish Law Commission, in its *Report on the Legal Capacity and Responsibility of Minors and Pupils* came to the conclusion that the best interests test was too restrictive and unnecessary. If it is accepted that a child may consent if he is of sufficient maturity to understand the treatment proposed then the test of maturity should be the determinative factor, whether the treatment concerned is in his or her best interests or not.¹²⁸

5.114 The *Children (Scotland) Act 1995*, it is worth noting, also omits any mention of welfare, which has been viewed as a signal to the court that in a dispute between parent and child, the welfare principle would not be determinative.¹²⁹ A competent child could, in principle, reach a decision which is objectively viewed as jeopardising his or her best interests. Section 90 of the 1995 Act states that where a competent child is required to submit to an

¹²⁶ See discussion of *The Children (Scotland) Act 1995* in Elliston *The Best Interests of the Child in Healthcare* (Routledge Cavendish 2007) at 77.

¹²⁷ Sections 1(1)(b) and (9) *Age of Legal Capacity (Scotland) Act 1991*.

¹²⁸ Scottish Law Commission *Report on the Legal Capacity and Responsibility of Minors and Pupils* (Report 110 1987) at 3.77.

¹²⁹ McConnell “Children’s Informed Consent to Treatment: The Scottish dimension” (1995) 21(3) *J Med Ethics* at 186- 187.

examination or treatment, the examination or treatment shall only be carried out with the child's consent. The legal capacity of a competent child to refuse to submit to examination or treatment under section 90 may be indicative of a broader power of refusal. However, similar statutory provisions in English legislation have not been interpreted this way, as discussed above in relation to the *Children Act 1989*.¹³⁰

5.115 *In re Houston, Applicant*¹³¹ involved a 15 year old boy, who was deemed competent under section 2(4) of the 1991 Act and was resisting an application under section 18 of the *Mental Health (Scotland) Act 1984*. The mother of the minor in question maintained that a section 18 order was not necessary as she could provide the necessary consent. The central question to be decided was whether parental consent could override the refusal of a competent minor.

5.116 Sheriff Mc Gowan accepted evidence that although the patient was suffering from a psychotic illness, he was competent to make a decision about his admission and treatment. He was therefore entitled to make up his own mind about consenting or refusing to consent to the treatment. Sheriff Mc Gowan held that section 2(4) of the 1991 Act applied to both consent and refusal, therefore the consent of the patients mother could not override his refusal:

“It seem to be illogical that, on the one hand a person under the age of 16 should be granted the power to decide upon medical treatment for himself while, on the other hand, his parents have the right to override his decision. I am inclined to the view that the minor's decision is paramount and cannot be overridden”¹³²

5.117 The section 18 order was granted. The judge in this case clearly took a different, and a preferable view, to that of Lord Donaldson in the case of *Re R and Re W*, discussed above.¹³³ However there are limitations to the *Houston* case.¹³⁴ There were serious doubts raised over consent of the minor's mother and the nature of a section 18 order is that treatment is given whether the

¹³⁰ *South Glamorgan County Council v W and B* [1993] 1 FLR 574 626. See 5.80 above.

¹³¹ [1996] SCLR 943.

¹³² At 945.

¹³³ At 5.82.

¹³⁴ See Grubb “Refusal of Treatment: Competent Child and Parents” 5 *Med. L. Rev.* (1997) at 237-259, Elliston *The Best Interests of the Child in Healthcare* (Routledge Cavendish 2007) at 114.

patient consents or not.¹³⁵ Moreover, there was no detailed discussion of the distinction, if any, to be drawn between consent and refusal, nor was there a discussion on the power of the court to override the boy's refusal. It remains to be seen therefore, how a case of refusal by a section 2(4) competent minor would be judged by the courts in Scotland.

5.118 Guidance issued by the NHS to health professionals in Scotland states that where a child has capacity to make the health care decision in question, the 1991 Act requires that the child's decision should be respected, even where it differs from the opinion of the health professional and the child's parents.¹³⁶ In relation to refusal, the guidance states that refusal of consent by or on behalf of a child may be overridden by the courts under Section 11(2) of the 1995 Act, which provides for applications in relation to parental rights and responsibilities. An application for a specific issue order can be made by a person with an interest, such as a doctor.

(5) Australia

5.119 The common law in Australia recognises the mature minor rule, as discussed in Chapter 4.¹³⁷ The High Court of Australia adopted the mature minor rule in *Secretary, Dept of Health and Community Services v. JWB 1992*¹³⁸ also known as Marion's Case. Referring to the judgment of Lord Scarman in the *Gillick* case, the High Court stated that:

“This approach, though lacking the certainty of a fixed age rule, accords with experience and with psychology. It should be followed in this country as part of the common law.”¹³⁹

5.120 It appears that the *Gillick* case is widely accepted and the test of capacity laid down in *Gillick* has been extended to a wider range of cases than those involving health care.¹⁴⁰

¹³⁵ The Sheriff stated that the mother's position could not properly be described as consenting.

¹³⁶ A Good Practice Guide on Consent for Health Professionals in the NHS Scotland (Scottish Executive Health Department 2006).

¹³⁷ At 4.76.

¹³⁸ *Secretary, Dept of Health and Community Services v JWB and SMB* [1992] 175 CLR 218.

¹³⁹ *Ibid* at 237.

5.121 There is limited case law in Australia in relation to the legal capacity of a minor to refuse medical treatment. In Marion's Case the court briefly referred to refusal of treatment by young people but did not endorse the principles laid down by the English Court of Appeal in *Re R* and *Re W*.¹⁴¹ The joint judgement of Mason CJ, Dawson, Toohey and Gaudron JJ contained a footnote referring to *Re R* but also citing criticism of the Court of Appeal's decision:

“As to the priority of parental rights and the capacity of a child to refuse medical treatment for mental illness, see In *Re R*... But also see the comment on Lord Donaldson's judgment by Bainham in “The Judge and the Competent Minor...”

5.122 The right of a minor to refuse medical treatment remains unclear, but a court can, in its welfare jurisdiction, override a young person's refusal of treatment. It is not certain whether the refusal of a mature minor can be overridden by parental consent however in view of the criticism mentioned in the preceding paragraph, it is somewhat unlikely.

(i) Western Australia

5.123 As discussed in Chapter 4,¹⁴² the issue of medical treatment for minors was addressed by the Law Reform Commission of Western Australia in 1988, with the recommendation that children aged 16 should be able to consent to medical treatment as if they were of full age, and the common law mature minor rule should be preserved for children under the age of 16.¹⁴³ The Commission felt that young people aged 16, and competent children under 16, should have an absolute right to consent, and parents would not have the right to override the decision of consent or refusal made by their competent child.¹⁴⁴ Disputes over the maturity of the child, or the treatment in question could be resolved by a court exercising an appropriate guardianship jurisdiction.¹⁴⁵

¹⁴⁰ Queensland Law Reform Commission *Consent to Health Care of Young People: Volume One* (Report 51 1996) at 52.

¹⁴¹ See 5.82.

¹⁴² At 4.79.

¹⁴³ Law Reform Commission of Western Australia *Medical Treatment for Minors* (Discussion Paper 77-1 1988) at 5.1. The reference of the project was withdrawn in 1988. No recommendations had been made by the Commission upon that reference

¹⁴⁴ *Ibid* at 5.12.

¹⁴⁵ *Ibid* at 7.5.

5.124 In relation to life sustaining treatment, the Supreme Court of Western Australia held in *Minister for Health v A.S*¹⁴⁶ that the court will almost always override a child's decision to refuse life-sustaining or life-prolonging treatment, in accordance with the child's best interests. The case involved a 15 year old Jehovah's Witness who had the capacity to understand the nature and consequences of the proposed treatment, but refused on religious grounds. Pullin J stated that the court's power in the inherent jurisdiction to countermand the wishes of a child patient is to be exercised sparingly and with great caution, however there are cases where it is necessary to do so. The views of the child are of course relevant to the best interests analysis and the court shall exercise great caution in overturning them, however these wishes alone shall not be determinative.

5.125 The court also relied on Section 21 of the *Human Tissue and Transplant Act 1982*, which states that a medical practitioner may perform a blood transfusion upon a child without the consent of any person who is legally entitled to authorise the transfusion.¹⁴⁷

(ii) Queensland

5.126 In 1996 the Queensland Law Reform Commission published a significant body of research on *Consent to Health Care of Young People*, including a draft bill based on different presumptions of maturity and ability to consent for different age groups.¹⁴⁸ Under the draft Bill, the older age group of competent 16-17 year olds can refuse medical care.¹⁴⁹

(iii) South Australia

5.127 South Australia has enacted a comprehensive legislative scheme relating to consent to health care by young people. Section 6 of the *Consent to Treatment and Palliative Care Act 1995* states that

“A person of or over 16 years of age may make decisions about his or her own medical treatment as validly and effectively as an adult”

¹⁴⁶ [2004] WASC 286, 33 Fam. L.R. 223.

¹⁴⁷ Where, in the opinion of two medical practitioners, the child is likely to die without the transfusion.

¹⁴⁸ Queensland Law Reform Commission *Consent to Health Care of Young People* (Report 51 1996).

¹⁴⁹ The draft Bill has not been enacted.

5.128 It is unlikely that the phrase “make decisions about” would be interpreted more narrowly so as to exclude a decision to refuse treatment and it is clear that the wishes of 16 and 17 year olds prevail over those of their parents. It is unclear however, whether the *parens patriae* jurisdiction of the courts in South Australia has been excluded for competent 16 and 17 year olds. Section 12 states that for young people under 16, the consent of either a parent or the young person is effective. A parent may be able to seek a court order prohibiting, in the interests of a young person, performance of health care to which the young person has consented. The court would then have to decide the dispute according to the principle that the welfare of the young person is paramount.¹⁵⁰ The South Australian provision does not appear to alter the common law position as set out by the English courts *In Re W* but, as outlined above, it is not certain whether the Australian position regarding refusal to treatment will follow the English precedence.¹⁵¹

(iv) New South Wales

5.129 In 2008, the New South Wales Law Reform Commission published a Report on *Young People and Consent to Health Care*, recommending that a competent young person may accept or refuse health care.¹⁵² A young person is competent, if in the opinion of the health practitioner offering the health care, the young person understands the information that is relevant to making a decision about the health care, and appreciates the reasonably foreseeable consequences of that decision. A young person aged 16 years or over is presumed to be competent to make a decision about his or her health care, but this presumption can be rebutted if, in the opinion of the health care practitioner, the young person does not understand the information that is relevant to making a decision about the health care and does not appreciate the reasonably foreseeable consequences of the decision.¹⁵³

5.130 The New South Wales Commission resolved any doubts over possible co-existing parental rights to make decisions about the health care of a young person. A health care practitioner must not rely on the acceptance or refusal of health care of a parent or guardian on a young person’s behalf if that acceptance or refusal conflicts with the young person’s decision where the young person is competent to make a decision about his or her health care. The

¹⁵⁰ See discussion in Queensland Law Reform Commission *Consent to Medical Treatment of Young People* (Discussion Paper 44 1995) at 148.

¹⁵¹ See 5.121.

¹⁵² New South Wales Law Reform Commission *Young People and Consent to Healthcare* (Report 119-2008) at xiv.

¹⁵³ *Ibid.*

courts retain the power to intervene in decisions affecting young people which are not thought to be in their best interests.¹⁵⁴

5.131 The authority of the courts to intervene and make orders in respect of a child's medical treatment was determined by the New South Wales Supreme Court in 1999.¹⁵⁵ The case concerned a 15 year old anorexic who refused treatment for her condition and seemed to be supported by her parents in her refusal. Austin J stated that the Court's power in the inherent jurisdiction to countermand the wishes of the child is to be exercised sparingly and with great caution, however there may be cases where it is necessary to do so, as in the present case.¹⁵⁶

(6) New Zealand

5.132 Section 36 of the *Care of Children Act 2004* states that a consent or refusal to any medical, surgical or dental treatment or procedure, (including blood transfusions) given by a child over the age of 16 has effect as if the child were of full age, where the treatment or procedure is to be carried out on the young person for the young person's benefit.¹⁵⁷

5.133 Section 37 contains a form of protection for doctors who administer blood transfusions to a person who is under 18 years of age. The provision outlines a broad range of conditions which, if met, prevent a judge from granting leave to bring criminal, civil or disciplinary procedures against a health practitioner who administered a blood transfusion without the necessary consent.

5.134 It is not clear whether parents retain a co-existing right to consent or refuse medical treatment for their 16 year old child. Sections 30 of the 2001 Act states that the High Courts and Family Courts have concurrent jurisdiction in respect of children and may make an order placing a child under the guardianship of the court, either generally or for any particular purpose, such as giving consent for medical treatment.¹⁵⁸

¹⁵⁴ *Ibid* at 131.

¹⁵⁵ *DoCS v Y* [1999] NSWSC 644.

¹⁵⁶ Austin J at para 103.

¹⁵⁷ The *Care of Children Act 2004* replaced the *Guardianship of Infants Act 1968*. Section 25 of the *Guardianship of Infants Act* was enacted in the same form in the 2004 Act and is similar to section 8 of the UK *Family Law Reform Act 1969* and section 23 of the *Non-Fatal Offences Against the Person Act 1997*.

¹⁵⁸ Skegg & Paterson *Medical Law in New Zealand* (Thompson Brookers 2006) at 203.

5.135 The 2004 Act does not confer any rights on children under the age of 16, aside from the right to consent or refuse a termination of pregnancy. It has been argued however that the common law mature minor rule has been adopted into New Zealand law and the consent of those under 16 is effective in law.¹⁵⁹

5.136 Section 11 of the *New Zealand Bill of Rights Act 1990*, which applies equally to children, states that everyone has the right to refuse to undergo any medical treatment. This provision is constrained however by Section 5 which states that rights and freedoms may be subject to reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.¹⁶⁰

5.137 The legal situation regarding the refusal of a competent minor under the age of 16 remains to be seen, however, it seems likely that in a situation where the life of a minor was threatened by the refusal of medical treatment, the courts would intervene and authorise the treatment.

D Discussion

5.138 Looking again at the English case law, there appears to be an inconsistency in the way in which the mature minor rule is applied when a minor refuses medical treatment. Firstly, the concurrent powers of consent retained by the parents of a mature minor is at variance with the basis of the rule, namely that parental rights and duties in relation to consent to medical treatment exist only as long as the minor is incapable, in that the minor does not have the capacity for such a level of decision making. Secondly, the standard of maturity needed to satisfy the test for capacity rises and falls in accordance with whether the minor is consenting or refusing medical treatment. The law on consent and refusal as it has been interpreted in England appears to discriminate on the grounds of age and outcome, in contrast to the functional capacity approach adopted in *Gillick*.¹⁶¹ The law in England therefore seems to operate on the anomaly that a child can say yes to medical treatment but cannot say no. This is highly questionable because, as Herring has pointed out, the forced administration of treatment in spite of a patient's opposition seems to be a

¹⁵⁹ See New South Wales Law Reform Commission *Young People and Consent to Healthcare* (Report 119-2008) at 125.

¹⁶⁰ Thompson "Whose Right to Choose? A Competent child's Right to Consent to and Refuse Medical Treatment in New Zealand" 8 *Canterbury L. Rev.* (2001-2002) 145 at 173.

¹⁶¹ Freeman, "Rethinking Gillick" (2005) *International Journal of Children's Rights* at 212.

greater violation of personal rights than the denial of treatment which the patient requests.¹⁶²

5.139 The recent changes however made to mental health legislation in England should end the practice of relying on child welfare legislation in order to ensure that a minor receives psychiatric treatment. Also, the best interests approach taken in *Re M*¹⁶³ is preferable to some of the alternative judicial approaches to the operation of the mature minor rule in the context of refusal.

5.140 A point raised by Freeman is that the distinction between consent and refusal is not always clear, for example there may be a range of therapeutic options available, some of which the minor refuses and some of which he or she consents to. Perhaps the adolescent wishes to consent to experimental or alternative treatment however the practitioner only offers conventional treatment which the adolescent refuses. Refusal of treatment does not necessarily entail the refusal of all treatment. This point was also made by Abella J in the Canadian Supreme Court.¹⁶⁴

5.141 Fortin has raised the issue that an adolescent forced to undergo treatment may find Articles 3, 5 and 14 of the European Convention on Human Rights (ECHR) offer the possibility for a successful challenge to the treatment.¹⁶⁵ Forcing an adult patient to undergo medical treatment can involve 'inhuman or degrading treatment' unless the treatment in question is completely orthodox and deemed essential. The same principle should apply to minors. If a minor comes before the courts refusing life sustaining treatment, however, Article 2 of the ECHR can provide a solution.¹⁶⁶ Where a minor's rights under the Convention are in conflict, a balance must be struck between them in favour of preserving life. Taking children's rights seriously does not commit the law to endangering their future health and well-being. Fortin draws on an interest theory of rights to confirm the role to be played by paternalism in order to protect future choice.¹⁶⁷

¹⁶² Herring *Family Law* (3rd ed, Pearson Longman, 2007) at 432

¹⁶³ See 5.93.

¹⁶⁴ *A.C. v Manitoba (Director of Family Services)* [2009] SCC 30 at paragraph 46.

¹⁶⁵ Fortin *Children's Rights and the Developing Law* (2nd ed Butterworths 2003) at 130.

¹⁶⁶ Article 2 "Everyone's right to life shall be protected by law."

¹⁶⁷ See Fortin *Children's Rights and the Developing Law* (2nd ed Butterworths 2003) at 129.

5.142 It is arguable that seriously ill minors have a right to greater protection of the law than adults however this does not mean that standards of capacity and competence should be adjusted to the extent that a finding of capacity is unattainable. While it is understandable that the courts rule in favour of preserving the life of a young person, consistency could be achieved if this was openly articulated. Although the paternalistic approach taken by the courts in certain cases negates adolescent autonomy, such an approach seeks to protect the interests of children and young people and prevents them from making irreversible decisions with grave consequences.

5.143 The *Gillick* case, hailed as a triumph for children's rights, was based on a functional capacity approach. Such an approach is time and issue specific, in that it is possible for a young person to be competent to make a decision about one type of health care but not another. A decision to refuse treatment often has more serious consequences than a decision to consent to treatment. In relation to the refusal of life sustaining treatment, the decision takes on additional magnitude. It may be the case that very few adolescents have the mental capacity to make such a momentous decision. The courts could openly state that in the vast majority of cases involving adolescent refusal of life sustaining treatment the courts will rule in favour of preserving life, to promote the self interest of the adolescent.

5.144 Enforced survival into adulthood may not however always be in the best interests of the child or adolescent. There may be cases where the preservation or prolonging of life actually damages an adolescent's self interest. Cases of adolescents dealing with terminal and long term illness come to mind.¹⁶⁸ The principle of best interests, informed by the views of the child, could be relied on as a method of ensuring that when a refusal truly is in the best interests of the child, the decision of the child shall be upheld by the court. It is important to note, as discussed in chapter one, that an evaluation of best interests must be carried out in a holistic manner, informed by spiritual and emotional factors as well as physical.¹⁶⁹

¹⁶⁸ See Bridge "Religious Beliefs and Teenage Refusal of Medical Treatment" (1999) 62 Mod L Rev 585 at 593.

¹⁶⁹ See discussion of best interests at 1.41.

E Options for Reform

5.145 The law in Ireland in relation to consent has upheld the personal rights of autonomy and bodily integrity. Respect for personal rights of autonomy is extended to young people who have the capacity to make health care decisions. This respect encompasses all decisions, including a decision to refuse a certain course of treatment.

5.146 Returning to the scheme of consent to medical treatment outlined in chapter 4, a person who is 16 years of age is presumed to have capacity to consent and refuse health care and medical treatment. It would be highly inconsistent and at variance with the principle of autonomy to suggest that a 16 year old who is presumed to have the capacity to make health care decisions can only consent to treatment. The Law Society of Ireland's Law Reform Committee has recommended that minors aged 16 and 17 should have the capacity to consent to, and refuse medical treatment.¹⁷⁰

5.147 *The Commission recommends that it should be provided in legislation that a person who is 16 years of age is presumed to have capacity to consent and refuse health care and medical treatment. The word presumption in this regard is intended to reflect the presumption in law that a person of 18 years of age has full capacity.*

5.148 In relation to refusal of life sustaining treatment, there is an instinctive desire to preserve life. Thus, an application could be made to the High Court for adjudication of the purported refusal, which would be carried out in the best interests of the young person. The High Court could intervene to order treatment which is necessary to save life and is in the best interests of the young person, in accordance Article 2 of the ECHR.¹⁷¹ In the event of such an application, the minor should be represented by a guardian *ad litem*.¹⁷²

5.149 Such an approach would respect the view that minors should be protected against choices which irreversibly limit their future choices. In light of the criticism of the development of the law in England in relation to concurrent powers of consent, parents would not retain a power of veto over a competent young person's decision.

¹⁷⁰ Law Society's Law Reform Committee *Rights-based Child Law: The Case for Reform* (Law Society of Ireland, 2006) at 203.

¹⁷¹ Art 2 ECHR "Everyone's right to life shall be protected by law."

¹⁷² Law Society's Law Reform Committee *Rights-based Child Law: The Case for Reform* (Law Society of Ireland, 2006) at 203.

5.150 *The Commission provisionally recommends that, in the context of refusal of life sustaining treatment a person who is 16 years of age may make an application to the High Court to have his or her purported refusal appraised.*

5.151 *The Commission invites submissions on the refusal of life sustaining treatment by a person aged 16 years or older.*

5.152 The Law Society of Ireland's Law Reform Committee has recommended the introduction of a functional capacity test, based on the test in Gillick, to determine the capacity of minors under 16 years of age to consent to and refuse medical treatment. Returning to the scheme of consent outlined in chapter 4, a person who is 14 years of age but less than 16 years of age, can, subject to certain requirements, be regarded as capable of giving consent to health care and medical treatment, provided he or she has the cognitive capacity to understand the nature and consequences of the treatment being provided. This is a functional capacity test based on the specific decision to be made. If the adolescent in question had the capacity to make a decision to refuse treatment this would be upheld, based on the principles of autonomy and consent. In relation to life sustaining treatment, as discussed above, few adolescents have the mental capacity to make such a momentous decision. As with the recommendation outlined above, parents would not retain a power of veto over a competent young person's decision however there would be an option to apply to the High Court for adjudication of the purported refusal. In the event of such an application, the minor should be represented by a guardian *ad litem*.¹⁷³

5.153 *The Commission provisionally recommends that a person who is 14 years of age but less than 16 years of age could, subject to certain requirements, be regarded as capable of giving consent and refusal to health care and medical treatment, provided he or she has the capacity to understand the nature and consequences of the treatment being provided. Such requirements would include:*

- *In the opinion of the medical practitioner, the patient understands the nature and consequences of the proposed treatment*
- *The medical practitioner shall encourage the patient to inform his or her parents or guardians*
- *The medical practitioner must consider the best interests of the patient.*
- *The medical practitioner shall have due regard to any public health concerns*

¹⁷³ *Ibid.*

5.154 *The Commission invites submissions on the refusal of treatment by a person aged 14 years but less than 16 years.*

5.155 Under the scheme of consent to medical treatment outlined in chapter 4, it shall be lawful for a health care professional to provide treatment to a person who is 12 years of age but less than 14 years of age. There is no presumption of capacity in this regard and the rationale behind this reform is to ensure that young adolescents can access necessary health care and medical treatments.

5.156 *The Commission provisionally recommends that it shall be lawful for a health care professional to provide health care and medical treatment to a person who is 12 years of age but less than 14 years of age, provided that the health care professional has complied with certain requirements. Such requirements would include:*

- *It is mandatory for the medical practitioner to notify the parents/guardian of the child and take account of their views*
- *The medical practitioner must take account of the views of the child in question*
- *The medical practitioner must consider the best interests of the patient.*
- *The medical practitioner shall have due regard to any public health concerns*

5.157 *The Commission provisionally recommends that children aged 12 years of age but less than 14 years of age may not be regarded as capable of refusing medical treatment.*

F Advance Care Directives

5.158 The term 'advance care directive' is used to describe the advance expression of wishes by a person, at a time when they have the capacity to express their wishes, about certain treatment that might arise at a future time when they no longer have the capacity to express their wishes.¹⁷⁴ While much of the focus of advance care directives inevitably concerns end of life decisions they also involve the continuation of care. The focus is not purely on refusal of medical treatment, and advance care directives care directives must be seen in the wider setting of overall health care planning, particularly in the context of children and young people dealing with long term illness.

¹⁷⁴ Law Reform Commission *Bioethics: Advance Care Directives* (LRC 94 -2009) at 2.

5.159 Presently in Ireland, there is no legal framework for the creation of advance care directives by persons under 18 years of age. As the Commission has reiterated throughout this paper, it is of the utmost importance to involve children in the management of their health care plans, to facilitate their participation and allow them to develop the skills to make decisions and assume responsibility for aspects of their health care.

5.160 The Commission's 2009 *Report on Advance Care Directives* recommended that the proposed legislative framework should apply to persons over the age of 18 years. This was to ensure consistency with its previous proposals for reform of the law on mental capacity contained in its 2006 *Report on Vulnerable Adults and the Law*¹⁷⁵, which is due to be implemented in the Government's *Scheme of a Mental Capacity Bill 2008*. This project affords the Commission an opportunity to address the submissions made to the 2008 *Consultation Paper on Bioethics: Advance Care Directives*.

5.161 The *Consultation Paper on Bioethics: Advance Care Directives* sought submissions as to the age a person must be before they can make an advance care directive. In relation to capacity, it was submitted that an assessment by a trained and experienced professional, of a young person is crucial in determining capacity, rather than assuming capacity purely on the basis of age. Therefore, if an advanced care directive is being considered by or for a person under 18 years of age, a major part of such a directive should be a formal assessment of the competence of that person to understand all the implications of their advance care directive.

5.162 Looking at other jurisdictions in relation to the legality of advance care directives made by persons under 18 years of age, it seems that the age at which an advance care directive may be recognised ranges from 16-18 years of age. In England, section 24 of the *Mental Capacity Act 2005* states that a person may make an advance decision "after he has reached 18". Looking to Canada, the provinces of Manitoba¹⁷⁶, Saskatchewan¹⁷⁷, and Newfoundland and

¹⁷⁵ Law Reform Commission *Vulnerable Adults and the Law* (LRC 83-2006).

¹⁷⁶ Section 4 of the *Health Care Directives Act C.C.S.M. 1992* "In the absence of evidence to the contrary, it shall be presumed for the purpose of this Act (a) that a person who is 16 years or more has the capacity to make health care decisions (b)that a person who is under 16 years of age does not have the capacity to make health care decisions.

¹⁷⁷ Section 3 of the *Health Care Directives and Substitute Decision Makers Act, SS 1997* "Any person 16 years of age or more who has the capacity to make a health care decision may make a directive".

Labrador¹⁷⁸ have enacted legislative provisions which enable persons aged 16 years or over to make advance directives.

5.163 The Commission has concluded that persons aged 16 years and older are presumed to have capacity to consent to and refuse medical treatment. There is no reason therefore, to deny competent 16 year olds the opportunity to fully engage in health care planning by making advance care directives.

5.164 The Commission has not addressed the issue of advance care directives in the context of mental health care. To quote from the report on *Bioethics: Advance Care Directives*:

“The Commission accepts, of course, that an advance care directive made in the context of a recurring illness history and the use of effective medication during previous psychiatric episodes could improve the person’s adherence to a treatment plan, with its consequent benefits in terms of quality of life and reduced need for hospitalisation. Nonetheless the Commission has concluded that this aspect of advance care directives involves many issues in addition to those discussed in this Report, and is, therefore, deserving of separate analysis.”¹⁷⁹

5.165 As mentioned in Chapter 6¹⁸⁰, the Commission recognises the importance of health care planning in the context of mental health care.

5.166 *The Commission provisionally recommends that it should be provided in legislation that a person who is 16 years of age is presumed to have capacity to make an advance care directive. The word presumption in this regard is to reflect the presumption in law that a person of 18 years has full capacity.*

¹⁷⁸ Section 7 of the *Advance Health Care Directives Act SNL 1995* “For the purposes of this section there shall be, in the absence of evidence to the contrary, be a presumption.....(b) that a person who is 16 years of age or older is competent to make health care decisions

¹⁷⁹ Law Reform Commission *Bioethics: Advance Care Directives* (LRC 94-2009) at 1.83.

¹⁸⁰ At paragraph 6.115 and 6.141.

CHAPTER 6 MENTAL HEALTH

A Introduction

6.01 This chapter discusses medical services and legislation in relation to children and young people with mental health problems. Part B looks at the prevalence of mental health problems amongst children and adolescents in Ireland. Part C examines current service provision and Part D studies the impact of the *Mental Health Act 2001* on patients under the age of 18. Part E concludes with issues for discussion in relation to reform and the Commission's provisional recommendations.

B Mental Health Problems in Childhood and Adolescence

6.02 As discussed in Chapter 3, the extent of mental health problems amongst Irish children and young people is a growing concern¹. Children of any age can suffer from mental illness however adolescence in particular is a typical time for the development of mental health problems.

6.03 A range of studies have examined the prevalence of mental health disorders in adolescents in the developed world. Population based studies consistently estimate that 15% of adolescents have a mental health disorder with a quarter showing significant functional impairment.² A study carried out in 2006 to assess the prevalence of psychiatric disorders in Irish adolescents revealed rates of psychiatric disorders similar to those found in adolescents from other Western cultures. The study examined a community-based sample of urban adolescents aged 12-15 and found a range of significant mental health difficulties. 15.6% of the sample had a current psychiatric disorder and almost 20% met the criteria for a past psychiatric disorder.³ Despite the prevalence of psychiatric disorders, few adolescents had come to the attention of child and

¹ See para 3.61.

² *Get Connected: Developing an Adolescent Friendly Health Service* (National Conjoint Child Health Committee 2001) at 23.

³ Lynch et al "Challenging Times: Prevalence of psychiatric disorders and suicidal behaviours in Irish adolescents" (2006) 29 *Journal of Adolescence* at 568.

adolescent psychiatric services. The majority of those identified as meeting the criteria for a psychiatric disorder were not receiving any professional help.⁴

6.04 The 2008 *Annual Report of the Child and Adolescent Mental Health Services (CAMHS)* states that the majority of adult mental health disorders have their roots in adolescence and refers to a study which found that 74% of 26 year olds with mental illness had experienced mental illness before the age of 18 years. 50% of the group of 26 year olds had experienced mental illness before the age of 15 years.⁵

6.05 *The State of the Health of Our Children* report in 2000 looked at lifestyle factors which have a detrimental effect on the health and social wellbeing of children. A survey carried out in 1999 revealed that in relation to most behavioural indicators such as drug and alcohol consumption, the prevalence of risk behaviours for 16 year olds in Ireland was greater than the average of 30 other European countries⁶. A survey published by the National Suicide Research Foundation in 2004 found that serious personal, emotional, behavioural or mental health problems were experienced by 26.9% of teenagers surveyed⁷. Of these, only 17.8% received professional help⁸. One of the important conclusions drawn from the survey and of particular relevance to the Commission's current research, was that few adolescents seek medical help, largely due to fears over lack of confidentiality and lack of knowledge about where to go for medical support and help⁹.

6.06 Headstrong, the National Centre for Youth Mental Health, estimate that in Ireland, at any given time, one in five young people are experiencing serious emotional distress¹⁰. In 2009, Headstrong published a report called *Someone to Turn To, Someone to Talk To*. The report included a survey of 10,000 young people between the ages of 15-25, one in ten of whom reported

⁴ *Ibid.*

⁵ *Child and Adolescent Mental Health Services: First Annual Report 2008* (Health Service Executive 2009) at 6.

⁶ *Annual Report of the Chief Medical Officer Health of our Children* (Dublin: Department of Health 2000) at 88.

⁷ Sullivan et al *Young People's Mental Health: A Report of the Results from the Lifestyle and Coping Survey* (National Suicide Research Foundation 2004) at 15.

⁸ *Ibid.*

⁹ Sullivan et al *Young People's Mental Health: A Report of the Results from the Lifestyle and Coping Survey* (National Suicide Research Foundation 2004) at 30.

¹⁰ Bates et al *Someone to Turn To Someone to Talk to* (Headstrong 2009) at 16,18.

experiencing serious problems, yet did not seek professional help. Adolescents face a number of obstacles in accessing professional help, such as fees, long waiting lists, and limited opening hours¹¹. Also the referral criteria for accessing services exclude many young people, particularly those aged between 16 and 18.¹²

Suicide and Self Harm

“No matter what the particular route to suicide, it is without doubt one of the saddest events in human experience. It can leave devastation in its wake as relatives, friends and local communities struggle with trauma of inexplicable loss, shock and feelings of rejection.”¹³

6.07 There are approximately 400-500 deaths from suicide per year in Ireland¹⁴, not including incidents of attempted suicide and self-harm. Suicide affects people from all backgrounds and socio-economic groups, with rates of male suicide significantly higher than female although data has indicated that the number of female suicides may be increasing¹⁵.

6.08 The high rate of youth suicide is a particular cause of concern. At 15.7% per 100,000 of 15-24 year olds, Ireland has the fifth highest youth suicide rate in the European Union.¹⁶ Suicide is the leading cause of death among

¹¹ *Ibid* at 21.

¹² In respect of the operational criteria of CAMHS teams, only 10 consider new referrals of young people over 16 years, on a case by case basis. A further 6 teams accept referrals of children and adolescents up to 16 and 17 years of age, while the remaining 33 teams do not see new cases of young people aged 16 or 17, but will continue to see existing cases of patients aged 16 or 17 years of age.

¹³ *A Vision for Change: Report of the Expert Group on Mental Health Policy* (Stationary Office 2006) at 159.

¹⁴ *Reach Out: National Strategy for Action on Suicide Prevention 2005-2014* (Health Service Executive 2005) at 11.

¹⁵ *Get Connected: Developing an Adolescent Friendly Health Service* (National Conjoint Child Health Committee 2001) at 24. *Reach Out: National Strategy for Action on Suicide Prevention 2005-2014* (Health Service Executive 2005) at 12.

¹⁶ *National Office of Suicide Prevention: Annual Report 2006* (Health Service Executive 2007) at 1.

young people in Ireland, aged 15-24¹⁷. 40 children under fifteen years of age are known to have committed suicide over a recent ten year period¹⁸.

6.09 Deliberate self-harm is also a serious problem. Engaging in self-harm is the strongest predictor of future suicidal behaviour, both fatal and non-fatal¹⁹ 11,000 cases of deliberate self-harm, some of which are suicide attempts, present to Irish hospitals each year²⁰. This does not include the numbers of people who engage in deliberate self-harm without receiving medical attention. Deliberate self-harm is higher amongst younger age groups, particularly girls aged 15-19 years and boys aged 20-24 years. The Lifestyle and Coping Survey carried out by the National Suicide Research Foundation in 2004 found that overall, 12.2 % of teenagers surveyed had a history of repeated deliberate self harm²¹. The survey found that girls were three times more likely to harm themselves than boys. The annual reports of the National Office of Suicide Prevention reveals a significant pattern in the incidence of deliberate self-harm when examined by age, with incidence rates particularly high for young women. The 2008 annual report found that the peak rate for self-harm across age and gender is found amongst young women aged 15-19²².

C Adolescent Mental Health Services

6.10 Traditionally, under the *Mental Treatment Act 1945*, services have been targeted at children (aged up to 16 years) and adults (18 years and older), creating a gap in service provision for young people aged between 16 and 18 years of age. Adolescents caught between the 16 and 18 year old thresholds

¹⁷ *National Office of Suicide Prevention: Annual Report 2006* (Health Service Executive 2007) at 23.

¹⁸ *Get Connected: Developing an Adolescent Friendly Health Service* (National Conjoint Child Health Committee 2001) at 24.

¹⁹ Zahl and Hawton "Repetition of deliberate self-harm and subsequent suicide risk: long-term follow-up study of 11,583 patients." (2004) 139 *British Journal of Psychiatry* at 68-9, *A Vision for Change: Report of the Expert Group on Mental Health Policy* (Stationary Office 2006) at 160.

²⁰ *Reach Out: National Strategy for Action on Suicide Prevention 2005-2014* (Health Service Executive 2005) at 13.

²¹ Sullivan et al *Young People's Mental Health: A Report of the Results from the Lifestyle and Coping Survey* (National Suicide Research Foundation 2004) at 17.

²² *National Office of Suicide Prevention: Annual Report 2006* (Health Service Executive 2007) at 26, *National Office of Suicide Prevention: Annual Report 2008* (Health Service Executive 2009) at 28.

were subsumed into the general adult sphere and treated by adult psychiatrists. This situation was criticised because the specific needs of the adolescent population were not met. General adult psychiatrists do not have the training to deal with developmental or conduct disorders. Furthermore, adult services lack the necessary multidisciplinary input which centres on family, school and social interventions.

6.11 The *Mental Health Act 2001* sought to rectify this gap in services by extending child services to adolescents aged up to 18 years of age. By acknowledging that adolescents have particular needs which are not met in the general milieu of adult psychiatry, the Act aimed to provide a continuum of support for children as they progressed through adolescence and into adulthood. This legislative change brought the issue of treatment for 16-18 year olds to the fore and accelerated the debate on how the needs of a vulnerable group of young people can be best served²³.

6.12 Young people need accessible, user-friendly services, specific to their needs²⁴. International and domestic studies have shown that young people need someone to talk to, in a safe and confidential environment, to help them develop coping skills to deal with mental health problems²⁵. A vital aspect of health care for adolescents is simply to have a reliable person to confide in, to talk to about their difficulties and health concerns.

6.13 An important reoccurring point in the literature on adolescent mental health is the need for a holistic, preventative and community based approach to mental health services. In general, young people do not fare well in residential care, and the focus on providing more beds and more in patient care is not reflective of the wider needs of adolescents experiencing mental health difficulties.

6.14 It is widely acknowledged that mental health services are not meeting current demand and there are considerable gaps in service provision²⁶. It is

²³ Working Group on Child and Adolescent Psychiatric Services *Second Report* (Department of Health and Children 2003) at 7.

²⁴ *A Vision for Change: Report of the Expert Group on Mental Health Policy* (Stationary Office 2006) at 85. The 2001 and 2003 Reports of the Child and Adolescent Psychiatric Services have outlined the services needed, in line with internationally accepted best practice, to provide a holistic mental health service for children and adolescents.

²⁵ Bates et al *Someone to Turn To Someone to Talk to* (Headstrong 2009) at 23.

²⁶ KilKelly *Children's Rights in Ireland* (Tottel Publishing 2008) at 433, The Irish Times "Mental Health Services still do not reflect new policies" 15/05/2009, The Irish Times "Major gaps still exist in psychiatric teen services" 31/03/2009. Lynch

unfortunate that the legislative changes brought about by the *Mental Health Act 2001* have not delivered the necessary improvements to service provision for 16-18 year olds. The *Vision for Change* Report stated that Child and Adolescent Community Mental Health services (CAMHS) are well below the recommended norms and recommended the development of 99 multidisciplinary CAMHS teams, 54 of which are currently in place²⁷. Compounding the lack of teams is the fact that staff numbers in the 49 existing community teams are below recommended levels. Furthermore, 18 teams, representing over a third of community teams rated their premises as inadequate or totally unsuitable²⁸. The annual report of the CAMH services states that there is a significant variation in the distribution and disciplinary composition of the workforce across teams and regions²⁹.

6.15 The Mental Health Commission has stated that Child and Adolescent Mental Health Services with responsibility for providing services to all children up to the age of 18 have not been in a position to fulfil their obligations³⁰. Adolescents in the 16-18 year old age bracket are particularly vulnerable and in danger of falling through the cracks between child and adult mental health services.³¹ The 2008 *Annual Report* of the Mental Health Commission reiterated

et all “Challenging Times: Prevalence of psychiatric disorders and suicidal behaviours in Irish adolescents” (2006) 29 *Journal of Adolescence* at 570.

²⁷ *A Vision for Change: Report of the Expert Group on Mental Health Policy* (Stationary Office 2006) at 86. The 54 teams are made up of 49 community teams, 2 day hospital teams and 3 paediatric hospital liaison teams. Child and Adolescent Mental Health Services Annual Report 2008 (HSE 2009) at 3.

²⁸ *Child and Adolescent Mental Health Services: First Annual Report 2008* (Health Service Executive 2009) at 24.

²⁹ *Ibid* at 4.

³⁰ *Annual Report 2008: Book One Part Two* (Mental Health Commission 2009) at 63.

³¹ Existing services are not in a position to deal with the older adolescent age group of 16-18 year olds due to the increase in major psychiatric illnesses which occurs in this age group. Child psychiatry services are already stretched in catering for the mid adolescent age group of 13-15 year olds, who, in turn, have a propensity to take over from younger clients due to the high rate of emergency presentations with acute illness and suicide attempts.

that community facilities such as day hospitals and clinics are inadequate, and waiting for an appointment can take longer than a year³².

6.16 A report of the National Conjoint Child Health Committee in 2001 highlighted the absence of adequate services and revealed that, on average, every Child and Adolescent Psychiatrist has a waiting list of 50 people.³³ Cases referred to CAMHS are screened, with urgent cases seen as a priority and others placed on a waiting list.³⁴ Looking at the statistics in the CAMHS annual report, 45.6% of new cases were seen within 4 weeks of referral, 67.4% were seen within 13 weeks, 12% had waited between 13 and 26 weeks, 8.7% had waited between 26 and 52 weeks and 11.9% had waited more than a year to be seen. The *Annual Report* of the Mental Health Commission contained a breakdown of waiting lists in different catchment areas. Waiting times varied greatly, from one year up to three years.³⁵ In November 2008, a total of 3,117 children and adolescents were waiting to be seen.³⁶

6.17 Another significant problem is the lack of forensic services for children and young people. Mental health problems are prevalent among Irish children and adolescents who come into conflict with the law, and are entering a system which provides few opportunities for assessment and treatment.³⁷

³² *Annual Report 2008: Book One Part Two* (Dublin: Mental Health Commission 2009) at 63.

³³ *Get Connected: Developing an Adolescent Friendly Health Service* (National Conjoint Child Health Committee 2001) at 25.

³⁴ In 2008, 76.6 % of referrals were from general practitioners and child health services, 9.4% of referrals were from educational services, 5.6% were from primary care services, 3.2% of referrals were from social services, 2.7% of referrals were self referrals and 2.4% of referrals were from other sources. *Child and Adolescent Mental Health Services: First Annual Report 2008* (Health Service Executive 2009) at 14.

³⁵ *Annual Report 2008: Book One Part Two* (Mental Health Commission 2009) at 93.

³⁶ 18 (37%) of CAMHS community teams had a waiting list of less than 25 cases, 2 (4%) had a waiting list of 24-49 cases, 20 (40%) had a waiting list of 50 to 99 cases, 5 (10%) had a waiting list of 100-149 cases and 4 (8%) had a waiting list of more than 150 cases. *Child and Adolescent Mental Health Services: First Annual Report 2008* (Health Service Executive 2009) at 4.

³⁷ Kilkelly, *Barriers to the Realisation of Children's Rights in Ireland* (Office of the Ombudsman for Children 2007) at 26, *A Vision for Change: Report of the Expert Group on Mental Health Policy* (Stationary Office 2006) at 141, See also Seymour

Concerns have also been raised over the lack of health and support services for children and adolescents in residential care, particularly special care units.³⁸ There can be quite a fine line between disruptive behaviour and mental health problems and it is vital that children in residential care have access to quality mental health services.

6.18 One of the main concerns in relation to essential services for children and young people is the shortage of approved centres for in-patient treatment. The acute shortage of approved centres for children means that children and adolescents are being admitted and detained in approved centres for adults, which could be seen as a violation of the European Convention on Human Rights (ECHR). The *Report on the Operation of Part 2 of the Mental Health Act 2001* stated that patients in hospital where conditions are particularly bad have relied on Article 3 and 8 of the ECHR to argue for improvements.³⁹

6.19 In 2003, the *Second Report of the Working Group on Child and Adolescent Psychiatric Services* stated that the practice of treating adolescents in adult psychiatric wards could continue, but only as an interim solution.⁴⁰ It seems, however, that this interim solution has been relied on as a long term arrangement. The Mental Health Commission referred to this practice as:

“inexcusable, counter-therapeutic and almost purely custodial in that clinical supervision is provided by teams unqualified in child and adolescent psychiatry.”⁴¹

6.20 The Mental Health Commission has consistently highlighted the absence of sufficient child and adolescent facilities, stating in 2008 that the

and Butler *Young People on Remand* (Office of the Minister for Children and Youth Affairs, 2008).

³⁸ The Annual Reports of the Social Services Inspectorate have highlighted the serious deficiencies in some residential care centres. Available at <http://www.hiqa.ie/publications.asp> See also Hanlon et al *The Impact of Placement in Special Care Unit Settings on the Wellbeing of Young People and their Families* (Special Residential Services Board 2004)

³⁹ *Report on the Operation of Part 2 of the Mental Health Act 2001* (Mental Health Commission 2008) at 84.

⁴⁰ *Working Group on Child and Adolescent Services: Second Report* (Department of Health and Children 2003) at 14.

⁴¹ *Annual Report 2008: Book One Part One* (Mental Health Commission 2009) at 29.

provision of age appropriate centres must be addressed as a matter of urgency.⁴²

6.21 The Ombudsman for Children has criticised the continued delay in implementing policy in the mental health field, particularly the practice of admitting children and adolescents to adult wards, the lack of health promotion around mental health and the lack of services for 16 and 17 year olds. In 2006 the Committee on the Rights of the Child expressed concern that children with mental health problems do not access help and some children are treated with adults in adult psychiatric facilities.⁴³ The Committee reiterated its earlier recommendations that Ireland implement the recommendations of the Expert Group on Mental Health Policy, undertake awareness-raising campaigns to prevent stigmatisation and ensure that the focus is on early-intervention, and continue its efforts to ensure that children with mental health difficulties benefit from specific services designed for children under 18 years of age.⁴⁴

6.22 In this context, recent legislative changes made to Section 131 of the UK *Mental Health Act 1983* by the *Mental Health Act 2007* have introduced new duties in relation to the provision of suitable accommodation for children. Section 131 of the 1983 Act as amended, provides that children and young people under the age of 18, admitted to hospital under the Act, should be accommodated in an environment that is suitable for their age. This means that children and young people should have appropriate physical facilities, a hospital routine that will allow their personal, social and educational development to continue, and equal access to educational opportunities. Staff should be trained and equipped with the skills and knowledge to understand and address the specific needs of children and young people.⁴⁵ Furthermore, in deciding how best to fulfil their duties under section 131, hospital managers must consult a person who has knowledge or experience of dealing with patients under the age of 18.⁴⁶

⁴² *Ibid.* The Annual Report of the Mental Health Commission stated that in 2008, 247 children and adolescents were admitted to adult units, representing 63% of total admissions. 223 (90%) of those admitted to adult centres were aged 16 or 17.

⁴³ Kilkelly *Children's Rights in Ireland* (Tottel Publishing 2008) at 433.

⁴⁴ Committee on the Rights of the Child *Concluding Observations: Ireland* CRC/C/IRL/CO/2 at 11.

⁴⁵ Department of Health *Code of Practice Mental Health Act 1983* (London TSO 2008) at 344.

⁴⁶ *Ibid.*

6.23 These changes were due, in part, to a report published by the Children's Commissioner for England, *Pushed into the Shadows: Young People's Experience of Adult Mental Health Facilities*.⁴⁷ The report revealed widespread negative experiences of young people on adult psychiatric wards. Many were bored, isolated, uninformed and uninvolved in decisions regarding their health care, whilst others had felt extremely unsafe⁴⁸.

6.24 The Mental Health Commission's Code of Practice acknowledges that in Ireland, children and adolescents continue to be treated in centres approved for adults only. The Code of Practice contains a list of provisions which should be in place to lessen the general unsuitability of such accommodation, for example staff should be vetted and trained in relation to the care of children, arrangements should be made to continue the child's education and a programme of activities appropriate to age and ability should be provided. The implementation of such provisions would help address an adolescent's special needs as a young person in an adult setting. Again, this is an interim solution and one hopes that the necessary facilities will be provided sooner rather than later. It is imperative that an adolescent, going through an important stage of physical and mental development, receives the correct treatment, encompassing family, school and community support.

6.25 In 2009, the Mental Health Commission published an addendum to the Code of Practice relating to the admission of children under the *Mental Health Act 2001*, aimed at phasing out the admission of children and adolescents to adult units and centres. By December 2011 no child under 18 years of age should be admitted to an adult unit in an approved centre, save in exceptional circumstances. Regarding children and adolescents who live a considerable distance away from the approved centres for children in Dublin, Meath, Cork and Galway, it is probable that they will fall under the category of exceptional circumstances, and continue treatment in local approved centres for adults (modified to address their needs) in order to remain close to family support.⁴⁹

⁴⁷ *Pushed into the shadows- young people's experiences of adult mental health facilities* (The Children's Commissioner for England 2007)

⁴⁸ *Ibid* at 8.

⁴⁹ At present, the approved centres for children are in Dublin, Meath Cork and Galway, with two new units due to open in Galway and Cork in 2010. *Child and Adolescent Mental Health Services: First Annual Report 2008* (Health Service Executive 2009) at 4. See *Child and Adolescent Mental Health Services First Annual Report* (HSE 2009) at 4.

6.26 Despite the lack of progress on child and adolescent mental health services, there are examples of innovative and creative service provision by individual health care professionals and teams throughout the country, who have responded to the particular needs of children and adolescents whilst working with limited resources. Various community groups have come together with health care professionals to provide educational and social support to children and young people who are receiving treatment for mental health illnesses.

6.27 It is clear that the realisation of the goals set in the *Vision for Change Report* is largely dependent on the allocation of significant resources. To quote from the Annual Report of the Mental Health Commission:

“It is obvious that in Ireland there is a major discrepancy between the services provided and the identified needs of children and adolescents with mental health problems. The frustration of parents and staff is apparent, and children and adolescents who require assessment and interventions lose valuable time while waiting for essential services..... There should be recognition of the fact that children with mental health problems need timely access to adequate services, in order to attain their full potential, and these should be provided as a matter of urgency.”⁵⁰

D Mental Health Act 2001

6.28 The *Mental Health Act 2001* has been in force since the 21st of November 2006. The Act establishes a new framework for mental health services and seeks to comply with human rights obligations by ensuring review of detention of people who suffer from a mental disorder.

6.29 The 2001 Act applies to both children and adults, and defines a child as a person below the age of 18 years. This definition is in line with the *Child Care Act 1991* and presumably was intended to rectify the unsatisfactory situation under the *Mental Health Treatment Act 1945*, where young people aged 16 and 17 years were treated alongside adult patients. As already mentioned, adolescents have specific developmental and social needs that cannot be met through the general practice of adult psychiatry. The enactment of the 2001 Act has not however, resulted in the necessary improvements to

http://www.mhcirl.ie/Registration_of_Approved_Centres/List_of_Approved_Centres.pdf

⁵⁰ *Annual Report 2008: Book One Part Two* (Mental Health Commission 2009) at 95.

child and adolescent mental health services, particularly in relation to services for 16-18 year olds.

6.30 The provisions of the 2001 Act on children have incorporated various aspects of the *Child Care Act 1991*, which primarily legislates for children in care. There has been little consideration of the interaction between the 2001 Act and section 23 of the *Non-Fatal Offences Against the Person Act 1997*, which states that a minor aged 16 years of age is capable of consenting to medical treatment. The definition of a child is stated clearly in the 2001 Act as a person under 18 years of age, however there is no mention of capacity to consent and the relationship between section 23 of the 1997 Act and the 2001 Act raises questions over the status of consent or refusal given by a child aged 16 under the 2001 Act.⁵¹

6.31 Donnelly has stated that it is arguable that the 1997 Act sets the age of consent at 16.⁵² Bearing this in mind, there is nothing in the 2001 Act to exclude the application of the 1997 Act and nothing in the 1997 Act to suggest that it does not apply to treatment for a mental disorder.⁵³ The Mental Health Commission's Code of Practice acknowledged the confusion over the application of the 1997 Act and stated that although the definition of medical treatment under the 1997 Act may include psychiatric treatment, the position is not so clear as to enable the Commission to proceed on that basis⁵⁴.

6.32 It is clear that under the *Mental Health Act 2001*, a child is defined as a person under the age of 18 years however the regrettable absence of guidance in relation to the consent of a competent young person under 18 years of age has led to uncertainty over the applicability of section 23 of the 1997 Act. The stance taken by the Mental Health Commission in the Code of Practice, that medical and health professionals may need to obtain legal advice in relation to individual cases, highlights the need for clarification⁵⁵. In its *Report on the Operation of Part 2 of the Mental Health Act 2001*, the Mental Health Commission recommended that the interface of the provisions of the 2001 Act

⁵¹ Keyes "Guarded Welcome for Mental Health Bill 1999" (2000) 6(1) *Medico Legal Journal of Ireland* at 29, De Vries "The New Mental Health Bill-Failing to be Progressive" (2000) 6(1) *Medico Legal Journal of Ireland* at 26.

⁵² Donnelly "Treatment for a Mental Health Disorder: The Mental Health Act 2001, Consent and the Role of Rights" 40 *Irish Jurist* 2005 at 239

⁵³ *Ibid.*

⁵⁴ *Code of Practice Relating to the Admission of Children under the Mental Health Act 2001* (Mental Health Commission 2006) at 14.

⁵⁵ *Ibid* at 14.

with those of the *Non-Fatal Offences Against the Person Act 1997* be clarified to provide practitioners with clearer guidance as to their powers and functions.⁵⁶

(a) Mental Disorder

6.33 The definition of a mental disorder in the *Mental Health Act 2001* applies to both children and adults, as do the categories of involuntary and voluntary admission:

“In this Act ‘mental disorder’ means mental illness, severe dementia or significant intellectual disability where-

- (a) Because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons, or
- (b) (i) Because of the severity of the illness, disability or dementia, the judgement of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission
(ii) the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit or alleviate the condition of that person to a material extent.”⁵⁷

6.34 A person can be subject to an involuntary admission order if he or she is suffering from a mental disorder⁵⁸.

(b) Voluntary Admission

6.35 A voluntary patient is defined as “a person receiving care and treatment in an approved centre who is not the subject of an admission order or a renewal order”. The definition is a negative one, in that it is centred on what a voluntary patient is not, rather than what a voluntary patient is. The definition was discussed by the Supreme Court in 2009 during a *habeas corpus* application⁵⁹. The applicant in question sought an order that her detention in an approved centre was contrary to the provisions of Article 40.4 of the

⁵⁶ *Report on the Operation of Part 2 of the Mental Health Act 2001* (Mental Health Commission 2008) at 90.

⁵⁷ Section 3 of the *Mental Health Act 2001*.

⁵⁸ Section 14 of the *Mental Health Act 2001*.

⁵⁹ *E.H. v St Vincent's Hospital & Ors* [2009] IESC 46.

Constitution and that she was not a truly voluntary patient in the centre for a period of time. The applicant also sought a declaration that the definition of voluntary patient in Section 2 of the *Mental Health Act 2001* as found by the High Court is incompatible with Article 5 of the ECHR⁶⁰.

6.36 The case centred on a period of time where the applicant's involuntary detention was not renewed by a renewal order, due to the omission of a date in the renewal form. At the time, the consultant psychiatrist spoke to the patient and explained that she was no longer the subject of an order detaining her in the unit. The consultant psychiatrist stated that the patient verbally agreed to remain in the approved centre as a voluntary patient. However, the patient did not sign the voluntary admission form. Hospital records indicated that due to her mental illness she did not have the capacity to sign the form. Approximately two weeks later, the patient attempted to leave the unit but was prevented from doing so. In view of her attempts to leave the unit, procedures under the 2001 Act were invoked and the applicant was detained as an involuntary patient. At the date of the hearing, the applicant's involuntary detention had been renewed and the applicant remained in the unit as a patient under an involuntary admission order.

6.37 The core issue of the case centred on the invocation of Section 23 and 24 where a voluntary patient, who is suffering from a mental disorder attempts to leave an approved centre and whether it is necessary to make an admission order to change the status of the patient under the *Mental Health Act 2001*. During the course of the judgement, the definition of a voluntary patient was raised and discussed, however the issue was not a determinative factor in the case.

6.38 Counsel for the applicant submitted that the applicant was not truly a voluntary patient at the time in question as she did not sign the voluntary consent form, and was prevented from leaving the unit. Furthermore, counsel contended that, properly understood, the definition of "voluntary patient" in the Act had to be taken as meaning a person who freely and willingly consented to remaining in hospital. This definition was clearly not satisfied by the applicant, as her mental condition precluded her giving of such consent. The applicant's detention as a voluntary patient had the effect of circumventing the procedures contained in section 23 and 24 of the *Mental Health Act 2001*. Counsel accepted that the applicant was suffering from a serious mental illness however this did not change the fact that her detention was unlawful.

⁶⁰ Article 5 European Convention on Human Rights –“Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law....”

6.39 In response, counsel for the respondents stated that the definition of voluntary patient had a particular meaning and that meaning was not repugnant to the provisions of the Constitution, nor did it violate the rights of the applicant under Article 5 of the ECHR. Counsel also argued that the submission advanced on behalf of the applicant was contrary to the scheme and spirit of the 2001 Act, which was a legislative scheme put in place for the better protection of such persons as the applicant.

6.40 In his judgment, Kearns J stated that ‘voluntary patient’ was given a very particular meaning in section 2 of the 2001 Act:

“It does not describe such a person as one who freely and voluntarily gives consent to an admission order. Instead the express statutory language defines a “voluntary patient” as a person receiving care and treatment in an approved centre who is not the subject of an admission order or a renewal order.”

6.41 Kearns J stated that the definition must be construed and applied in accordance with the Constitution and the provisions of the ECHR. He also stated that:

“Any interpretation of the term in the Act must be informed by the overall scheme and paternalistic intent of the legislation...”

6.42 Kearns J concluded that such an approach to interpretation was taken in an earlier case, regarding a provision of the *Mental Treatment Act 1945*, and he did not see why a different approach should be adopted in relation to the 2001 Act.⁶¹

6.43 Kearns J referred to section 4 of the *Mental Health Act 2001* to emphasise that the 2001 Act was designed with the best interests of persons with mental disorder in mind.⁶² As the applicant in question was suffering from a mental disorder, it was in her best interests that she be detained in hospital.

⁶¹ *Gootden v St Otterman's Hospital* [2005] 3 IR 617.

⁶² Section 4(1): In making a decision under this Act concerning the care or treatment of a person (including a decision to make an admission order in relation to a person), the best interests of the person shall be the principal consideration with due regard being given to the interests of other persons who may at risk of serious harm if the decision is not made.

Section 4(3): In making a decision under this Act concerning the care or treatment of a person (including a decision to make an admission order in relation to a person) due regard shall be given to the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy.

“Mere technical defects, without more, in a patients detention should not give rise to court, notably where any such defect can or has been cured-as in the present one.”

6.44 The judgment did not centre on the definition of voluntary patient, but rather on the purposive interpretation of the *Mental Health Act 2001*, and the correct application of section 23 and 24 of the Act.

6.45 It is submitted that a voluntary admission must necessarily contain an element of choice and voluntariness on behalf of the patient to consent to detention and treatment. A voluntary patient is not the subject of an admission or renewal order and therefore is not suffering from a mental disorder under section 2 of the Act. Accordingly, a voluntary patient is treated as having the capacity to voluntarily consent to detention and treatment.

6.46 As mentioned above the definitions and categories of mental disorder, voluntary and involuntary, are applied to both children and adults. There are, however, significant differences in the practical application of these terms and definitions.

6.47 The admission of adults, which centres on voluntary or involuntary admission, is different to the practice used to admit children. Looking at the admission of children, it seems that although the distinction between a voluntary and involuntary patient is used, the distinction is circumvented in practice. The Mental Health Commission’s *Reference Guide* states that the majority of children requiring in-patient treatment for a mental illness or a mental disorder will be admitted at the request of their parents or guardians as voluntary patients.⁶³ The extent to which a child or an adolescent’s admission, based completely on the consent of his or her parents can be deemed as a voluntary admission, is questionable. The practice of admitting a child “voluntarily” on the basis of parental consent has been criticised and is out of line with children’s rights principles⁶⁴. The Law Society of Ireland’s Law Reform Committee has advocated reform in this area, stating that as a child under the Act cannot consent to admission, a child admitted by parental consent should not be called a voluntary patient.⁶⁵

⁶³ *Reference Guide Mental Health Act 2001: Part Two Children* (Mental Health Commission) at 4.2.1.

⁶⁴ *Kilkelly Children’s Rights in Ireland* (Tottel Publishing 2008) at 435, Law Society’s Law Reform Committee *Rights-based Child Law: The Case for Reform* (Law Society of Ireland 2006) at 208.

⁶⁵ Law Society’s Law Reform Committee *Rights-based Child Law: The Case for Reform* (Law Society of Ireland 2006) at 208.

6.48 The Mental Health Commission's *Code of Practice* states:

“where a child who is 16 years or older is being treated as a voluntary patient in an approved centre on the basis of consent given by his or her parents, it would appear that the child would not have a right to leave as such.”⁶⁶

6.49 The term voluntary is not an accurate description of a patient who has not given consent to his or her admission, cannot consent to treatment and cannot leave the centre. Furthermore, children who are detained as voluntary patients do not have the protections and safeguards granted to children detained as involuntary patients, such as review of their admission, discussed below at 6.79. The approach of the Commission is to extend and strengthen the rights of children and young people who are admitted and treated as voluntary patients under the *Mental Health Act 2001*. Safeguards relating to the involuntary placement of minors should be at the very least, as stringent as safeguards applying to the involuntary admission of adults⁶⁷.

6.50 Where the distinction between a voluntary and an involuntary patient is blurred, it is doubtful if appropriate safeguards can be applied. Anecdotal evidence presented to the Commission suggests that the process of involuntary admission is being circumvented by simply obtaining parental consent to admit children and young people as voluntary patients. When an application under section 25 is being made, the name of the approved unit where the child or young person is to be admitted, must be stated in court. Due to the lack of services, including spaces in approved centres for children and particularly adolescents, it is possible that the process of voluntary detention, based on parental consent, is favoured as the easy option over the formal section 25 court application. The definition of a voluntary and an involuntary patient are completely different and it is highly unsuitable to treat the terms as interchangeable by circumventing procedures of involuntary admission.

6.51 The European Court of Human Rights has addressed the issue on several occasions, notably in *Storck v Germany*⁶⁸. The case concerned a German woman who spent 20 years in psychiatric institutions and hospitals.

⁶⁶ *Code of Practice Relating to the Admission of Children under the Mental Health Act 2001* (Mental Health Commission 2006) at 15.

⁶⁷ Fortin *Children's Rights and the Developing Law* (2nd ed Butterworths 2003) at 141, Council of Europe *White Paper on the protection of human rights and dignity of people suffering from a mental disorder, especially those placed as involuntary patients in a psychiatric establishment* (Council of Europe 2000) at 8.1

⁶⁸ (2005) 43 EHRR 96. See also *Nielson V Denmark* (1988) 11 EHRR 175, *HL v UK* 45508/99 [2004] ECHR 471.

She was originally admitted at the age of 15, against her wishes, at the request of her father. She was detained and treated for 7 months and then released. Three years later she was detained at a different institution, again against her wishes, and also at her father's request. In 1994 and 1999 expert reports stated that the applicant had never suffered from schizophrenia, despite receiving treatment for the disorder, and her behaviour had been caused by conflicts with her family. The ECtHR held that Member States have a positive obligation under Articles 5 and 8 of the European Charter of Human Rights to ensure that there is effective supervision and review of decisions to detain or to treat without consent⁶⁹. Furthermore, Member States are under an obligation to provide effective supervision and review of deprivations of liberty and interferences with the physical integrity of a young person⁷⁰.

(c) Admission under the UK Mental Health Act 1983⁷¹

6.52 Criticisms were voiced in England over a practice, similar to the current situation in Ireland, where children were admitted informally to psychiatric institutions, by their parents or guardians. Section 11 of the *Mental Health Act 1983* stated that an application for admission for assessment, an application for admission for treatment and a guardianship application could be made by the nearest relative of the patient or an approved social worker. Section 7 of the *Mental Health Act 1983* provided that a 16 year old could be received into guardianship, if

“(a) he is suffering from a mental disorder, being mental illness, severe mental impairment, psychopathic disorder or mental impairment and his mental disorder is of a nature or degree which warrants his reception into guardianship under this section;

(b) it is necessary in the interests of the welfare of the patient or for the protection of other persons that the patient should be so received⁷²”

⁶⁹ 43 EHRR 96 at 113.

Art 5 ECHR --“Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law...”

Art 8 ECHR --“Everyone has the right to respect for his private and family life, his home and his correspondence....”

⁷⁰ Fenell *Mental Health: The New Law* (Jordans 2007) at 305.

⁷¹ As amended by the *Mental Health Act 2007*.

⁷² Section 7 of the *Mental Health Act 1983*.

6.53 Section 8 set out the powers granted to a guardian, to the exclusion of any other person:

“(a) the power to require the patient to reside at a place specified by the authority or person named as guardian;

(b) the power to require the patient to attend at places and times so specified for the purposes of medical treatment, occupation, education or training;

(c) the power to require access to the patient to be given, at any place where the patient is residing, to any registered medical practitioner, approved social worker or other person so specified.”

6.54 In 1985 *Gillick v West Norfolk and Wisbech Area Health Authority* changed the way in which the law viewed the capacity of children to consent to medical treatment, including psychiatric treatment⁷³. As a result of the judgment made by the House of Lords, a child may consent to medical treatment, including psychiatric treatment if they are over 16, or under 16 but *Gillick* competent. *The Children Act 1989*, in recognition of the *Gillick* case, contained several provisions stating that if a child is of sufficient understanding, he or she may refuse to submit to a medical or psychiatric examination⁷⁴. Schedule 3 of the Act, dealing with supervision orders, states that in relation to psychiatric and medical examinations and treatments, no court shall include such a requirement in a supervision order unless it is satisfied that where the child has sufficient understanding to make an informed decision, the child has consented to the inclusion of the requirement.⁷⁵

6.55 Under the *Mental Health Act 1983*, adults and children can be admitted informally if they have capacity and consent to admission. However, the practice of admitting a child informally with consent from a parent or guardian led to questions over the circumstances, if any, where this practice should be used⁷⁶. The practice of admitting a child informally with parental consent seemed to have arisen, in part, from the fact that the principles governing the compulsory admission of an adolescent to a unit did not carry

⁷³ Discussed in detail at 3.83 and 4.52.

⁷⁴ Section 38(6) Section 43(8) Section 44(7) of the *Children Act 1989*.

⁷⁵ Schedule 3 Part 1 Section 4 and 5 of the *Children Act 1989*. See discussion at 5.81.

⁷⁶ Fortin *Children's Rights and the Developing Law* (2nd ed Butterworths 2003) at 145-148.

legal authority to treat the patient against his or her wishes⁷⁷. Therefore, the easiest way for practitioners to obtain the necessary consents was to seek parental authority for 'informal admission' and treatment. Furthermore, health care professionals treating mentally ill minors have been reluctant to invoke the powers under mental health legislation. The reason put forward for this was the perceived stigma attached to the use of mental health legislation, and the effect this could have on the patient in later years. The judiciary appeared to accept this view in the cases of *Re R* and *Re W*, discussed in detail in chapter 6.⁷⁸ The decision to refuse treatment, made by young people in the cases of *Re R* and *Re W* came before the court because of a reluctance to engage the *Mental Health Acts* and a desire to avoid stigma. In *Re R*, Lord Donaldson stated:

“Although mental illness should not be regarded as any different from physical illness, it is not always so viewed by the uninformed and the fact that later in life it might become known that a minor had been treated under the Acts might rebound to his or her disadvantage⁷⁹”

6.56 This statement seems to add weight to the view that although a child may be suffering from a mental disorder, he or she should not be formally detained, but rather detained as a voluntary patient, under parental consent. This approach, whilst avoiding stigma in later life, circumvents the necessary protections in place for patients with a mental disorder who are formally detained and treated. Also, incorrect categorisation as an informal patient may have implications for the treatment that a patient with a mental disorder receives or does not receive.

6.57 In more recent times it seems that attitudes in England regarding the use of mental health legislation in relation to children and young people have changed, with doctors more prepared to rely on the legislation, particularly when treating eating disorders in older children. In 2002 the government issued a consultation document, stating that safeguards would be introduced to protect children and young people who could otherwise be treated against their wishes, but with their parent's consent⁸⁰. The document stated that 16 and 17 year olds should have a greater say in decisions which affect their lives, and would be

⁷⁷ *Ibid* at 142.

⁷⁸ *Re R (a minor) (wardship: consent to medical treatment)* [1991] 4 All ER 177. *Re W (a minor) (medical treatment: court's jurisdiction)* [1992] 4 All ER 627. See discussion at 5.82.

⁷⁹ *Mental Health Bill: Consultation Document* (Cm 5538-III Department of Health TSO 2002) at 10.

⁸⁰ *Ibid*.

treated as adults under the new legislation⁸¹. The document also stated that action would be taken to protect children under the age of 16, who are so ill, that without parental consent, they would meet the conditions for compulsion⁸².

6.58 Following the 2002 consultation document, Section 131 of the *Mental Health Act 1983* was amended by Section 43 of the *Mental Health Act 2007* to end the informal admission of 16 and 17 year olds on the basis of parental consent. As a result of the changes made by the 2007 Act, 16 and 17 year olds who have capacity under the *Mental Capacity Act 2005* may consent to informal admission, even where one or more persons may have parental responsibility for them. This is consistent with Section 8 of the *Family Law Reform Act 1969*⁸³, which as discussed in chapter 4, is the statutory precedent for Section 23 of the *Non-Fatal Offences Against the Person Act 1997*.⁸⁴

6.59 The Code of Practice on the 1983 Act contains a detailed chapter on the admission and treatment of children and adolescents⁸⁵. The Code refers to various concepts which are not directly applicable in Ireland, or have not been developed here to the same extent, such as parental responsibility, the zone of parental control, supervised community treatment and so on. Nevertheless, the Code provides a clear and detailed overview of how mental health law in England has changed in order to respect and safeguard the rights of children and young people. At the outset, general principles are laid down, stating that children and young people have as much right to expect their dignity and confidentiality to be respected as anyone else and they should be kept as fully informed as possible, as an adult would be. The best interests of the child or young person must always be a significant consideration. Also:

“any intervention in the life of a child or young person that is considered necessary by reason of their mental disorder should be the option that is least restrictive and least likely to expose them to

⁸¹ *Ibid.*

⁸² *Mental Health Bill: Consultation Document* (Cm 5538-III Department of Health TSO 2002) at 10.

⁸³ Section 8 is virtually identical to Section 23 of the 1997 Act “The consent of a minor who has attained the age of sixteen years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his person, shall be as effective as it would be if he were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian.”

⁸⁴ See 4.68.

⁸⁵ *Code of Practice Mental Health Act 1983* (Department of Health TSO 2008).

the risk of any stigmatisation, consistent with effective care and treatment, and it should also result in the least possible separation from family, carers, friends and community or interruption of their education, as is consistent with their wellbeing.⁸⁶

6.60 The adolescent will be treated as an informal patient, even if a person with parental responsibility refuses to consent to the adolescent's admission and treatment. If the adolescent in question has capacity but does not consent to admission, he or she cannot be admitted by the consent of someone with parental responsibility. As discussed further below, a young person over the age of 16 who has capacity is treated as if he or she were an adult.

6.61 Looking firstly at admission, section 131 of the *Mental Health Act 1983* provides that 16 and 17 year olds with capacity⁸⁷ to consent to admission to hospital for treatment of a mental disorder, may themselves give consent or not, regardless of the views of a person with parental responsibility. Section 131 also applies to a 16 or 17 year old who has capacity but does not consent, possibly overwhelmed by the decision, or refuses to consent. In such a case, a person with parental responsibility cannot consent on their behalf. Consideration will be given to whether the patient satisfies the criteria for formal detention. If the criteria are not satisfied, but treatment is considered to be in the patient's best interests, it may be necessary to seek court authorisation. The key point here is that when a 16 or 17 year old with capacity does not consent to informal admission, the consent of his or her parent cannot simply be used as substitute consent to detain the young person.

6.62 Section 131 of the *Mental Health Act* does not apply to 16 and 17 year olds who lack capacity. The *Mental Capacity Act* may apply, but not if the admission and treatment amounts to a deprivation of liberty. In such a case, the legality of the admission should be assessed under common law principles. If the matter is within the zone of parental control, a person with parental responsibility may consent. If the matter is outside the zone of parental control, consideration will be given whether the patient satisfies the criteria for formal detention under the *Mental Health Act*. If the criteria are not satisfied, court authorisation may be sought.

6.63 Children who are under 16, but *Gillick* competent, may consent to informal admission, and additional consent from a person with parental responsibility is not required. In this regard, the patient's competence to consent

⁸⁶ *Code of Practice Mental Health Act 1983* (Department of Health TSO 2008) at 327.

⁸⁷ As defined in section 2 and 3 of the *Mental Capacity Act 2005*.

should be assessed carefully in relation to each decision that needs to be made, as the understanding for different interventions will vary considerably. Consent should be sought for different aspects of the patient's care, and blanket consent forms should not be used. Regarding refusal of a *Gillick* competent child, the courts have held in previous cases that a person with parental responsibility can overrule such a refusal. There is, however, no post-*Human Rights Act*⁸⁸ decision on this and there is a greater awareness of the autonomy of the competent child. It may be unwise, therefore, to rely on the consent of the person with parental responsibility. Again, consideration should be given to whether the child meets the criteria for formal admission and detention under the *Mental Health Act*. If not, it may be appropriate to seek court authorisation.

6.64 Looking at the case of children who are under 16 and not *Gillick* competent, a person with parental responsibility may consent on their behalf to informal admission, if the decision is within the zone of parental control. The child's views should also be taken into account. The weight accorded to these views will depend on the maturity of the child. Where a child has, for example been *Gillick* competent to make a decision but loses competence, the views expressed before losing competence should be taken into account and may act as parameters limiting the zone of parental control. Furthermore, the fact that a person with parental responsibility has informally admitted a child does not mean that consent has been given to all components of treatment. Consent should be sought for each aspect of care as it arises. If the decision to informally admit the child is outside the zone of parental control, or consent is not given by the person with parental responsibility, the child cannot be admitted. Again, consideration will be given to whether the patient satisfies the criteria for formal detention under the *Mental Health Act*. If the Act is not applicable, court authorisation may be sought.

6.65 All children and young people who are detained under the *Mental Health Act* have the same rights as adults to apply to the Mental Health Review Tribunal.⁸⁹ The Code of Practice highlights the importance of assisting children and young people so that they have access to legal representation at an early stage. If a child patient is admitted informally on his or her own consent, he or she may seek to leave hospital at any time, subject to the provisions under section 5 of the *Mental Health Act 1983*. A child patient admitted under parental consent may challenge that decision by invoking the inherent jurisdiction of the High Court, by seeking a specific issue order under section 8 of *the Children Act*

⁸⁸ The comparable legislation in Ireland is the *European Convention on Human Rights Act 2003*.

⁸⁹ *Code of Practice Mental Health Act 1983* (Department of Health TSO 2008) at 346.

1989, or by seeking judicial review on the grounds that their detention infringes a Convention right⁹⁰.

Reform

6.66 The *White Paper: A New Mental Health Act*, published in 1995, recommended that in cases where parental consent has been obtained but where the child objects to admission to an approved centre, the admission shall be by means of a court order⁹¹. This recommendation, which was not included in the *Mental Health Act 2001*, shows a level of awareness of the autonomy and rights of the child and would have gone some way to address the inadequacy of relying solely on parental consent to admit a child or a young person to a centre for psychiatric treatment.

6.67 It is clear that reform is needed to safeguard the rights of children and adolescents admitted by parental consent as voluntary patients. Also, the confusion created by the word “voluntary” in ordinary terms and the meaning attributed to it as a categorisation under the *Mental Health Act* should be clarified by new terminology. The categorisation of patients as voluntary or involuntary patients under the *Mental Health Act* is appropriate in relation to children and adolescents who consent to admission as voluntary patients, or are suffering from a mental disorder and are therefore categorised as involuntary patients. A third category however is needed, for children and young people who are not suffering from a mental disorder, yet are in need of treatment, and do not have the capacity to consent to admission as a voluntary patients. The term ‘informal’ is suggested here for such children and adolescents who are admitted by parental consent.

6.68 *The Commission recommends the introduction of a third category of informal admission for children and adolescents who are admitted under the Mental Health Act 2001 by parental consent.*

(d) Involuntary Admission

6.69 Section 25 of the 2001 Act outlines the procedure for the involuntary admission of children. A child admitted involuntarily is not subject to the same procedures of review as an adult admitted involuntarily. There is no automatic review of the admission order by the Mental Health Tribunal.

6.70 Under section 25(1) the Health Service Executive (HSE) may apply to the District Court for an order authorising the detention of a child in an approved centre, where it appears that the child in question is suffering from a mental disorder, and the child requires treatment which he or she is unlikely to

⁹⁰ Fennell *Mental Health: The New Law* (Jordans 2007) at 323.

⁹¹ *White Paper A New Mental Health Act* (Department of Health 1995) at 27.

receive unless an order is made under section 25. The child must be examined by a consultant psychiatrist, before the making of the application, if possible.⁹² The child or adolescent can be admitted and detained for treatment in an approved centre for a period not exceeding 21 days.

6.71 On application by the HSE, the original 21 day period of involuntary admission is reviewed by the District Court and may be extended for a further 3 months. Following further applications by the HSE, an order of detention can be made by the court for a period not exceeding 6 months and thereafter for periods not exceeding 6 months. Section 25(11), which deals with the application to detain the patient for a maximum period of 6 months (after the initial 3 month period) states that the court shall not make an order to that effect unless the child has been examined by a consultant psychiatrist and the court is satisfied that the child is suffering from a mental disorder.

6.72 There is no mechanism for a child or young person, detained under an involuntary admission order to appeal a decision or seek a review of his or her detention or treatment. It is submitted that the admission of children and adolescents under section 25 of the Act should be subject to review, similar to the system of automatic review in place for adult patients. The report of an independent consultant psychiatrist should also be used at each stage of admission or renewal.

6.73 In relation to children, it is clear that the 2001 Act has relied heavily on the *Child Care Act 1991* which recognises the District Court as the ultimate guardian of the child. This is reflected in section 25 of the 2001 Act where the review of the involuntary admission of children is performed by the court. Clearly, the District Court will act in the best interests of the child, however one could argue that a specialist Tribunal, made up of a panel of experts, which routinely reviews admission and renewal orders could similarly review orders in relation to children. The Law Society's Law Reform Committee has also questioned why the court, as opposed to the Mental Health Tribunal has jurisdiction over the renewal of detention of children⁹³. Although certain provisions of the *Child Care Act*, as incorporated into section 25 of the 2001 Act allow for the child to participate and express views, the provisions are not strong enough, as discussed below.⁹⁴

6.74 A Mental Health Tribunal is made up of a legal member, a lay person and a consultant psychiatrist. The *Reference Guide to the Mental Health Act*

⁹² See Section 25(2),(3) and (4) of the *Mental Health Act 2001*.

⁹³ Law Society's Law Reform Committee *Rights-based Child Law: The Case for Reform* (Law Society of Ireland 2006) at 210.

⁹⁴ 6.79.

states that the primary function of the Tribunal is to ensure the protection of the rights of patients⁹⁵. Patients have a right to attend the Tribunal if they wish and may be represented by a legal representative. As discussed earlier, children and young people benefit from a multidisciplinary approach, and the input from different members of a Tribunal would be more suitable and in tune with their needs. The Tribunal has significant expertise, has been successful to date, and is being promoted as a suitable arena to discuss the admission and treatment of a child or an adolescent, rather than the more formal setting of a court.

6.75 The Tribunals are intended to be inquisitorial, rather than adversarial and are designed to be less formal and rigid than the court setting⁹⁶. The aim of the Tribunal system is to create an open environment different to that of a court setting, to encourage people to express their views. It is important that a forum which reviews the admission and treatment of children and young people must respect Article 12 of the Convention on the Rights of the Child and give the child or young person the opportunity to express his or her views and give them due weight in accordance with his or her age and maturity. On balance, the Commission believes that a Tribunal would be the most suitable forum to make decisions in relation to the admission and treatment of children under involuntary admission orders. However such a Tribunal must be equipped with the necessary skills and understanding to create an age appropriate environment and respect the rights of the child or adolescent in question. Age appropriate in this context means that the psychiatrist on the Tribunal and the consultant psychiatrist should both have a speciality in child and adolescent psychiatry. The child or young person should have an independent advocate or representative.

6.76 *The Commission provisionally recommends that a Mental Health Tribunal (with an age appropriate focus) rather than the District Court should review the admission and treatment of children and young people as involuntary patients for the purposes of the Mental Health Act 2001.*

6.77 Looking again at section 25, it seems that the time frames and mechanism for review are flawed. The fact that the original 21 day period of detention may be extended for a further 3 months, by an ex parte application, without any medical report, is highly questionable and inconsistent with the mechanism for admission and renewal in place for adult patients admitted involuntarily under the Act. The time frames are excessive for children and adolescents, particularly when one considers the average length of stay in in-

⁹⁵ Reference Guide Mental Health Act 2001: Part One Adults (Mental Health Commission) at 1.8.1

⁹⁶ *Ibid* at 1.8.4.

patient units, which is between 12 days (admission to adult units) and 50 days (admission to child and adolescent services).⁹⁷

6.78 These points raise significant doubts over the compliance of the 2001 Act with personal rights of autonomy and bodily integrity. The *Review of the Operation of the Mental Health Act*, published in 2007 acknowledged that concerns over section 25 have been raised, such as the excessive time frame of 21 days, the absence of review by a Mental Health Tribunal and the fact that there is no provision for the view of the child to be taken into consideration. The Review however stated that the Minister was of the view that the provisions provided for in legislation ensure that the child's best interests are protected⁹⁸. The 2001 Act does contain certain safeguards to promote the rights of the child, primarily by incorporating provisions of the *Child Care Act* into section 25 of the 2001 Act⁹⁹. These provisions however are not sufficient in the context of children and young people with mental health problems, as discussed in the following paragraphs.

(e) Safeguards under Section 25

6.79 In considering an application to admit a child or extend an admission under section 25, the court is guided by provisions of the *Child Care Act 1991*. Section 24 of the Child Care Act states:

“In any proceedings before a court under this Act in relation to the care and protection of a child, the court, having regard to the rights and duties of parents, whether under the Constitution or otherwise, shall -

- (a) regard the welfare of the child as the first and paramount consideration, and
- (b) in so far as is practicable, give due consideration, having regard to his age and understanding, to the wishes of the child”.

⁹⁷ *Child and Adolescent Mental Health Services: First Annual Report 2008* (Health Service Executive 2009) at 5.

⁹⁸ *Review of the Operation of the Mental Health Act :Findings and Conclusions* (Department of Health and Children 2007) at 20

⁹⁹ Section 25(14): The provisions of sections 21, 22, 24 to 35, 37 and 47 of the *Child Care Act 1991*, shall apply to proceedings under this section as they apply to proceedings under those sections with the modification that references to proceedings or an order under Part III, IV or VI of that Act shall be construed as references to proceedings or an order under this section and with any other necessary modifications.

6.80 Kilkelly has discussed the limited nature of this provision, pointing to the fact that the court's duty to consider the child's wishes follows the duty to consider the child's welfare as paramount.¹⁰⁰ This indicates that the view of the courts as to what is in the best interests of the child comes first, before the views of the child. In relation to the voice of the child, the limitation of practicability gives the court considerable discretion regarding the circumstances in which the child's wishes should be taken into account. The second limitation on age and understanding suggests that if a child is considered too young or immature, his or her wishes do not merit consideration. Furthermore, the word 'wishes' as opposed to 'views' indicates a consideration of what the child wants, as opposed to a broader appreciation of the potential contribution of the child and his or her ability to help find a solution to the issue at hand. In essence, section 24 of the *Child Care Act 1991* does not ensure that the voice of the child is heard, in line with Article 12 of the UN Convention on the Rights of the Child.¹⁰¹

6.81 Sections 21 and 22 deal with the appeal, variation and discharge of orders. Section 22 states that the Court, of its own motion or on the application of any person may vary or discharge an order. In respect of section 25 of the *Mental Health Act*, this infers that a court can vary or discharge an order made under section 25. It is not clear whether a child or adolescent admitted under section 25 could use this provision, for example to have their admission reviewed. Practically speaking, this is unlikely as the 2001 Act is silent on the participation rights of children and young people and it is doubtful whether they are made aware of section 22 and their potential to utilise it.

6.82 Section 26 of the *Child Care Act* covers the appointment of a guardian *at litem*, stating that the court may, if it is satisfied that it is necessary in the interests of the child and in the interests of justice to do so, appoint a guardian *ad litem* for the child¹⁰². As discussed by Kilkelly, it is arguable that the interests of the child will always require the appointment of an independent person to represent them¹⁰³. In the context of children and young people detained under section 25 of the *Mental Health Act*, their interests would surely require the appointment of a guardian, as they have no effective way of securing review of their admission or treatment. The operation of the guardian *ad litem* in Ireland is subject to considerable confusion and criticism. There is no guidance offered to the court as to the circumstances where a guardian

¹⁰⁰ Kilkelly *Children's Rights in Ireland* (Tottel Publishing 2008) at 216.

¹⁰¹ See discussion of Article 12 at 1.39.

¹⁰² A guardian *ad litem* is an independent representative for a child.

¹⁰³ Kilkelly *Children's Rights in Ireland* (Tottel Publishing 2008) at 217.

should be appointed, what type of person may be appointed or what the function and role of the guardian should be¹⁰⁴. The practical utility of section 26 of the *Child Care Act* in relation to a child or adolescent under an involuntary admission order is somewhat doubtful.

6.83 Section 30 of the *Child Care Act 1991* provides for the presence of the child during a court hearing, however similar to the discussion above of section 24, section 30 is somewhat limited. There is no automatic right to be present and the court can proceed without the presence of the child. The section is worded in a way which seems to suggest that the presence of the child is the exception, rather than the rule. The first part of the provision states that the presence of the child is not required unless the court is satisfied that the presence of the child is necessary for the disposal of the case. The section then states that the child may request to be present and such a request shall be granted, unless, having regard to the age of the child and the nature of the proceedings it would not be in the child's interest to accede to the request.¹⁰⁵ There is no reference to the maturity of the child or his or her understanding of the issue at hand. Also, the utility of the request to be present depends largely on the child's knowledge that such a provision exists.

6.84 The relevant provisions of the *Child Care Act 1991* discussed above are only applicable under section 25 which deals with the involuntary admission of children. As mentioned earlier, the Mental Health Commission has stated that the majority of children are admitted by their parent or guardian and treated as voluntary patients.¹⁰⁶ Therefore the safeguards contained in section 25 do not apply to the majority of children and adolescents admitted under the 2001 Act.

¹⁰⁴ Shannon *Child Law* (Thompson Roundhall 2005) at 248, Carr "Guiding the GALs: A Case of Hesitant Policy-making in the Republic of Ireland" (2009) 12(3) *IJFL* at 60.

¹⁰⁵ Section 30 of the *Child Care Act 1991*: (1) It shall not be necessary in proceedings under Part III, IV or VI for the child to whom the proceedings relate to be brought before the court, or to be present for all or any part of the hearing unless the court, either of its own motion or at the request of any of the parties of the case, is satisfied that this is necessary for the proper disposal of the case.

(2) Where the child requests to be present during the hearing or a particular part of the hearing of the proceedings the court shall grant the request unless it appears to the court that, having regard to the age of the child or the nature of the proceedings, it would not be in the child's interests to accede to the request.

¹⁰⁶ *Reference Guide Mental Health Act 2001: Part Two Children* (Mental Health Commission) at 4.2.

6.85 The 2001 Act should be read and implemented bearing in mind the guidance laid down in the *Code of Practice*, namely that the best interests of the child shall be the principal and paramount consideration. Furthermore, all children receiving treatment pursuant to the Act should be involved, consistent with their identified needs and wishes, in the planning, implementation and evaluation of their care and treatment.

6.86 Section 4(2) of the 2001 Act states that a person shall, in so far as is reasonably practicable be notified of the proposed treatment and be entitled to make any representations in relation to it, and before deciding the matter due consideration shall be given to any representations made. There is no provision limiting section 4(2) to adult patients. The Mental Health Commission has stated the provision should be interpreted as applicable to children and has recommended that the best interests principle in section 4 be specifically restated in section 25.¹⁰⁷

6.87 It is doubtful however whether the guiding principles contained in the *Code of Practice* and the few safeguards under section 25 are adequate to provide a robust defence of children's rights, particularly their right to participate in health care decisions.¹⁰⁸ Children should not be denied adequate protection of their civil liberties, simply because of their age.

6.88 Children are afforded a special status because of their vulnerability and the fact that they are often dependent on adults to ensure that their rights are respected. Legislation must ensure that protective measures and safeguards are strong enough to uphold the rights of children in the context of mental health.¹⁰⁹

Reform

6.89 It is clear that reform is needed to safeguard the rights of children and adolescents who are suffering from a mental disorder and admitted as involuntary patients under section 25. An automatic review of admission by a Mental Health Tribunal would greatly improve the current situation of review by the District Court after a lengthy period of time. The provisions of the *Child Care*

¹⁰⁷ *Report on the Operation of Part 2 of the Mental Health Act 2001* (Mental Health Commission 2008) at 89.

¹⁰⁸ Kilkelly *Children's Rights in Ireland* (Tottel Publishing 2008) at 437.

¹⁰⁹ Principle 2 of the UN Principles for the Protection of Persons with Mental illness and the Improvement of Mental Health Care 1991 "Special care should be given within the purposes of these Principles and within the context of domestic law relating to the protection of minors to protect the rights of minors, including, if necessary, the appointment of a personal representative of a family member."

Act should be replaced with more appropriate guidelines which state that the best interests of the child are paramount, and the child's evolving capabilities shall be respected in line with Article 12 of the Convention on the Rights of the Child. A complete list of recommendations for reform is provided in Part E.

(f) Treatment

6.90 As stated above, the issue of consent in relation to psychiatric treatment for patients under the age of 18, but over the age of 16 is unclear. Theoretically, one could argue, as Kilkelly has pointed out, that a 16 year old cannot consent to placement in a mental health unit for the purposes of psychiatric treatment under the 2001 Act, but can consent to an assessment or surgical procedure undertaken while in such a unit under the 1997 Act¹¹⁰. This is unlikely however as the 2001 Act is silent on the issue of consent in relation to physical treatment because it assumes that consent is required for any such medical procedures which are outside the scope of the Act. Whilst this stance is appropriate in relation to adults, there are different considerations in relation to the capacity of a child or young person to consent to medical treatment, as discussed in chapter 4¹¹¹.

6.91 In relation to consent for psychiatric treatment, the Mental Health Commission's *Code of Practice* states that in order for treatment to be administered to a child admitted voluntarily, consent must be obtained from one or both of the child's parents¹¹². This point highlights the unsuitability of the term "voluntary" as applied to a patient who is admitted by parental consent. Although admitted as a voluntary patient, he or she cannot consent or refuse treatment. The adoption of the term 'informal' outlined above at 6.67 would reduce the confusion in this regard.

6.92 Section 61 of the 2001 Act regulates the provision of ongoing medication to a child who has been admitted by an involuntary admission order under section 25:

"Where medicine has been administered to a child in respect of whom an order under section 25 is in force for the purposes of ameliorating his or her mental disorder for a continuous period of 3 months, the administration of medicine cannot be continued unless **either**.

"(1) the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the child, **and** (2) the continued administration of that medicine is

¹¹⁰ Kilkelly *Children's Rights in Ireland* (Tottel Publishing 2008) at 436, De Vries "The New Mental Health Bill-Failing to be Progressive" (2000) 6(1) *Medico Legal Journal of Ireland* at 26.

¹¹¹ 4.02.

¹¹² *Code of Practice Relating to the Admission of Children under the Mental Health Act 2001* (Mental Health Commission 2006) at 13.

authorised (in a form specified by the Commission) by another consultant psychiatrist, following referral of the matter to him or her by the first-mentioned psychiatrist,

and the consent or, as the case may be, approval and authorisation shall be valid for a period of 3 months and thereafter for periods of 3 months, if, in respect of each period, the like consent or, as the case may be, approval and authorisation is obtained.¹¹³” (italics added)

6.93 The wording of the section is not clear, and has been termed confusing by the Law Society of Ireland’s Law Reform Committee. The Committee has recommended clarification and an amendment to section 61¹¹⁴. The use of the word ‘either’ followed by the word ‘and’ makes it unclear whether the consent of one or both psychiatrists is needed. The Mental Health Commission has been advised that the reference to consent is not comprehensive and appears to be inadequate¹¹⁵. The *Review of the Operation of the Mental Health Act 2001* addressed the issue, stating that the Minister accepted there was a drafting error which will be amended as soon as a suitable opportunity arises¹¹⁶. The Review gave no indication as to what form an amendment would take, save for the statement that the process for the detention of a child under section 25 is quite different to the involuntary admission of an adult and this is not correctly reflected in section 61.

6.94 For the time being, the Mental Health Commission has advised that both the approval of the consultant psychiatrist responsible for the treatment of the child, and authorisation from a second consultant psychiatrist is sought.¹¹⁷ Therefore, where medicine has been administered for a continuous period of three months, the continued administration of the medication requires the approval of the child’s consultant psychiatrist and the authorisation of a second consultant. As with section 60 of the 2001 Act, which regulates the administration of medicine to adult patients, this process must occur at 3 monthly stages. Section 61 does not include any requirement to consult with the

¹¹³ Section 61 of the *Mental Health Act 2001*.

¹¹⁴ Law Society’s Law Reform Committee *Rights-based Child Law: The Case for Reform* (Law Society of Ireland 2006) at 212.

¹¹⁵ *Code of Practice Relating to the Admission of Children under the Mental Health Act 2001* (Mental Health Commission 2006) at 22.

¹¹⁶ *Review of the Operation of the Mental Health Act 2001: Findings and Conclusions* (Department of Health and Children 2007) at 28.

¹¹⁷ *Code of Practice Relating to the Admission of Children under the Mental Health Act 2001* (Mental Health Commission 2006) at 22.

child. The Mental Health Commission's *Code of Practice* states that it is a matter for the treating psychiatrist to satisfy him or herself as to whether it is practicable and in the child's best interests to notify him or her of the proposal to administer treatment in accordance with section 4(2) of the 2001 Act.¹¹⁸ Section 61 does not include any requirement to consult with the parents of the child either, granting the consultant psychiatrist relatively unrestricted decision-making power.¹¹⁹

6.95 The omission of consent in section 61 is in direct contrast to section 60. A requirement to discuss the proposed treatment with the child or adolescent would strengthen the rights of the patient. The patient should have an opportunity to participate in the drawing up of an individualised treatment plan. Also, the three month period which passes before medication is approved under section 61 is excessive and should be reduced.

6.96 The common law doctrine of necessity is incorporated into the Act under section 57 which states that consent is not necessary where, in the opinion of the consultant psychiatrist, the treatment is necessary to safeguard the life of the patient, to restore his or her health, to alleviate his or her condition, or to relieve his or her suffering, and by reason of his or her mental health disorder, the patient concerned is incapable of giving such consent. Although section 57 does not refer to children, it can be assumed that the doctrine of necessity, as incorporated into the *Mental Health Act* is applicable to children and young people.

6.97 Section 25 of the 2001 Act requires court approval before psychosurgery or electro-convulsive therapy can be performed or administered to a child, but it is not necessary to obtain the consent or opinion of the child patient for any form of treatment. The child is not required to be present in court when the court is making decisions about his or her psychiatric treatment and detention. Again, it is questionable whether the District Court, rather than a Mental Health Tribunal is best placed to make such decisions which will have long lasting and irreversible effects. As discussed above, the view of the Commission is that a Tribunal, with an age appropriate focus, rather than the

¹¹⁸ Section 4(2) of the *Mental Health Act 2001*: Where it is proposed to make a recommendation or an admission order in respect of a person, or administer treatment to a person, under this Act, the person shall, so far as is reasonably practicable, be notified of the proposal and be entitled to make any representations in relation to it and before deciding the matter due consideration shall be given to any representations duly made under this section.

¹¹⁹ Donnelly "Treatment for a Mental Health Disorder: The Mental Health Act 2001, Consent and the Role of Rights"(2005) 40 *Irish Jurist* at 240.

District Court should review the admission and treatment of children and young people as involuntary patients for the purposes of the *Mental Health Act 2001*.

6.98 Looking at the provisions in relation to treatment under the UK *Mental Health Act 1983*, treatment for children and young people under the age of 18 with a mental disorder is regulated by the Act where a patient is detained, on supervised community treatment, or in some cases, an informal patient. The safeguards in force in relation to different treatments differ in relation to the capacity of the patient to consent, and the consent of the patient.

6.99 Part 4 of the *Mental Health Act 1983* deals mainly with the treatment of patients who have been detained in hospital, with some exceptions. The scheme of Part 4 is based on 'authority to treat' a patient, with the test 'that it is appropriate for the treatment to be given'. The primary authority to treat comes from the valid consent of the patient, treatment can however be authorised without the consent of the patient, as shown in the following paragraphs. The new test of 'appropriateness to treat' replaces the test that 'the treatment ought to be given having regard to the likelihood that it will alleviate or prevent deterioration in the patient's condition'¹²⁰.

6.100 Section 63 states that, unless sections 57,58 or 58A apply, detained patients may be given medical treatment for any kind of medical disorder if they consent to it, or have not consented to the treatment, but are given the treatment by or under the direction of the approved clinician in charge of treatment.

6.101 Section 57 of the 1983 Act applies to neurosurgery for a mental disorder and cannot be given to a child or young person unless the patient personally consents to it. Such treatment cannot be given to a child or young person who is not capable of consenting, even if consent is forthcoming from the person with parental responsibility. Section 58 applies to the administration of medicine to detained patients for the treatment of a mental disorder. Detained patients can be given medicine under section 58 if the approved clinician in charge of the treatment, or a second opinion appointed doctor (SOAD) certifies that the patient has the capacity to consent and has done so; or a SOAD certifies that the treatment is appropriate and the patient does not have the capacity to consent, or has the capacity to consent but has refused.

6.102 Section 58A of the 1983 Act deals with electro-convulsive therapy (ECT) and applies to detained patients, and all patients under the age of 18. The assessment of capacity carries great importance under section 58A. A

¹²⁰ Section 3(2) of the *Mental Health Act 1983*.

patient deemed capable can refuse ECT, but a patient deemed incapable can be given ECT, subject to a second opinion¹²¹.

6.103 A patient who is under 18 and has capacity to consent may be given ECT, if the SOAD certifies that the patient has the capacity to consent, has done so, and the treatment is appropriate. A detained patient, who is under 18 and not capable of giving consent, may be given ECT in accordance with certain requirements, namely that the treatment is appropriate, no valid and applicable advance decision has been made by the patient under the *Mental Capacity Act* refusing the treatment, no suitably authorised attorney or deputy objects to the treatment on the patient's behalf and the treatment does not conflict with a decision of the Court of Protection which prevents the treatment being given.¹²²

6.104 Patients under the age of 18, who are not detained, cannot be given ECT on the basis of the requirements outlined above. The patient's own consent or some other legal authority is needed. There is nothing in the Act to prevent a person with parental responsibility consenting to ECT on behalf of a child or young person who lacks the capacity to consent and is not detained. The Code of Practice, however, states that it would not be prudent to rely on such consent because it is likely to be outside the zone of parental control. Court authorisation should be sought instead.

6.105 This will also be the case for young people aged 16 and 17 who are not detained but lack the capacity to consent to ECT. The *Mental Capacity Act* can be used in such a case, but not if the treatment amounts to a deprivation of liberty. In situations where decisions about admission or treatment need to be made, but the action cannot be taken under the *Mental Capacity Act*, nor is it appropriate to use the *Mental Health Act*, the assistance of the High Court may be sought.

Reform

6.106 Section 61 is in need of clarification and reform, as stated in the *Review of the Operation of the Mental Health Act 2001*.¹²³ The three month period which passes before medication is approved under section 61 is excessive and should be reduced. Furthermore, the patient should be consulted

¹²¹ Fenell *Mental Health: The New Law* (Jordans 2007) at 285.

¹²² *Code of Practice Mental Health Act 1983* (Department of Health TSO 2008) at 204.

¹²³ *Review of the Operation of the Mental Health Act 2001: Findings and Conclusions* (Department of Health and Children 2007) at 28.

in relation to his or her treatment and given the opportunity to participate in drawing up an individualised treatment plan.

(g) Discussion

6.107 Looking at the UK *Mental Health Act 1983*, the amendments to the 1983 Act provide a complete and elaborate framework for treating children in hospital or in the community. Concerns have been raised, however, over the new broader definition of mental disorder and the new test in relation to treatment¹²⁴. The provisions in relation to treatment of children and adolescents who refuse treatment seem rather paternalistic and it is difficult to see how much weight their refusal carries in the decision of the clinician. Also, the fact that an approved mental health professional, such as a social worker, nurse, psychologist or occupational therapist may exercise compulsory powers of admission raises concerns over the lack of medical expertise involved in the admission of a patient. The ethos of the Act seems to be based on public protection and risk management, linked to the criminal justice system as opposed to safeguarding the rights of those detained.

6.108 In relation to people under the age of 18, however, the Act has brought about significant improvements, in particular ending the practice of informal admission based on parental consent, and the requirements regarding age appropriate accommodation. Fennell however has pointed to gaps in protection for children, notably in relation to the personal rights of a child under Article 8 of the ECHR and feeding by naso-gastric tube.¹²⁵

6.109 Bearing in mind the reform of the *Mental Health Act 1983* and the jurisprudence of the ECtHR, it is questionable whether the 2001 Act complies with children's rights principles. Several international instruments can be called upon to safeguard the rights of the child, particularly Article 12 of the Convention of the Rights of the Child¹²⁶, supplemented by the General Comment on Adolescent Health and Development, which emphasises the importance of respecting the evolving capacity of the child by including an obligation to take the views of adolescents into account, in accordance with their age and maturity.¹²⁷ Similarly, a 2004 European Council Recommendation requires that the opinion of the minor should be taken into account as an

¹²⁴ Fenell *Mental Health: The New Law* (Jordans 2007) at 25.

¹²⁵ Fenell *Mental Health: The New Law* (Jordans 2007) at 324.

¹²⁶ See discussion at 1.39.

¹²⁷ Committee on the Rights of the Child "*Adolescent health and development in the context of the Convention on the Rights of the Child*" (General Comment No 4 of 2003 CRC/GC/2003/4 1 July 2003).

increasingly determining factor in proportion to age and maturity, which serves to reinforce Article 6 of the 1997 Council of Europe Convention on Human Rights and Biomedicine¹²⁸.

6.110 A *Report on the Operation of Part 2 of the Mental Health Act*, published in 2008, received a substantial number of comments in relation to the voluntary and involuntary admission of children.¹²⁹ The comments were based on the perception of a reduced level of human rights protections and safeguards for children when compared with the regime for adults. The confusion over the relationship between section 23 of the *Non-Fatal Offences Against the Person Act 1997* and the *Mental Health Act 2001* was also raised.

6.111 The Law Society's Law Reform Committee has recommended resolving the conflict between the 1997 Act and the 2001 Act, so that children of 16 and 17 years of age are presumed to have capacity to consent to, or refuse medical psychiatric treatment as if they were of full age¹³⁰. Regarding voluntary admission of children, 16 and 17 year olds should be treated as adults. Where a child under the age of 16 is judged to have sufficient capacity in view of his or her age, maturity and understanding to consent to or refuse medical treatment, the child should be entitled to agree to voluntary admission or be admitted in accordance with the procedures under the *Mental Health Act 2001* as though the child were an adult. These recommendations by the Law Society's Law Reform Committee are similar to the changes made in the UK by the *Mental Health Act 2007*.

E Conclusion

6.112 It is evident that reform is essential in order to improve the rights of children and young people under the Mental Health Act 2001.

Separate Section for Persons Under 18

6.113 Firstly, the Act would benefit from increased clarity on the provisions relating to children and young people as they are somewhat lost in the Act.

¹²⁸ Art 6 "Where, according to law, a minor does not have the capacity to consent to an intervention, the intervention may only be carried out with the authorisation of his or her representative or an authority or a person or body provided for by law. The opinion of the minor shall be taken into consideration as an increasingly determining factor in proportion to his or her age and degree of maturity."

¹²⁹ *Report on the Operation of Part 2 of the Mental Health Act 2001* (Mental Health Commission 2008) at 84.

¹³⁰ Law Society's Law Reform Committee *Rights-based Child Law: The Case for Reform* (Law Society of Ireland 2006) at 208.

There is no specific section of the Act dealing with children, which creates confusion over which provisions are applicable to children and which are applicable to adults only. For example, the rules on seclusion and restraint contained in section 69 apply to children, but the rules contained in section 59 on ECT do not. There is also confusion over whether section 22, which provides for the transfer of a patient to hospital is applicable to patients under the age of 18.

6.114 Section 4 of the Act states that when making a decision under the Act regarding the care and treatment of a person, the best interests of the person shall be the principal consideration. This section does not refer to children, although the Mental Health Commission recommends that section 4 informs all actions undertaken in relation to children under the *Mental Health Act 2001*.¹³¹ A more concrete provision in the Act outlining the importance of the best interests of the child is necessary.

6.115 Throughout the course of the Commission's research on the subject, it has been agreed that the Act be amended, with the inclusion of a separate section for people under the age of 18. The separate section should contain a number of guiding principles to strengthen the rights of the child under mental health legislation such as:¹³²

- (a) The best interests of the child are paramount, and best interests should be defined in a way that is informed by the views of the child.
- (b) Children and adolescents should be treated in the least restrictive environment possible. Treatment administered to children and adolescents should be the least intrusive and restrictive treatment possible, and should be administered for the shortest possible period in accordance with an individualised care plan.
- (c) The evolving capacities of the child or adolescent be respected, by giving the child or adolescent the opportunity to express his or her views and such views should be given due weight in accordance with the age and maturity of the child in question.

¹³¹ *Code of Practice Relating to the Admission of Children under the Mental Health Act 2001* (Mental Health Commission 2006) at 11.

¹³² These guidelines were suggested by Amnesty International Ireland.

6.116 The provision of aftercare planning also needs to be addressed to ensure that support services are available to children and adolescents following discharge from an in-patient centre.

6.117 *The Commission provisionally recommends that the Mental Health Act 2001 be amended, with a separate section for people under the age of 18 and invites submissions on the form and content of guiding principles.*

Independent Advocacy

6.118 The Mental Health Commission, in its *Report on the Operation of Part 2 of the Mental Health Act 2001* recommended that increased emphasis be given to the rights of children by making it mandatory that children detained under the 2001 Act be appointed a legal representative and offered the services of an advocate. The Commission feels that independent and specialised advocacy services should be available to children and adolescents admitted and treated under the *Mental Health Act 2001*, as voluntary, involuntary or informal patients.

6.119 *The Commission recommends that all children and adolescents admitted and treated under the Mental Health Act 2001 should have access to an independent advocate.*

Informal Admission

6.120 In relation to children, the categorisation of involuntary or voluntary admission is not sufficient. A third category of informal admission would include children and adolescents who do not have the capacity to consent to admission and are admitted by their parents as informal patients. Informal patients would have their admission reviewed, in the same manner as the review of admission of an involuntary patient.

6.121 The requirements in relation to treatment would depend, in practice, on the capacity of the patient in question. The psychiatrist would have to discuss the proposed treatment with the child and his or her parents and give the patient an opportunity to participate in the drawing up of an individualised treatment plan. Ideally, a treatment plan would be decided upon by the patient, his or her parents, and the psychiatrist.

6.122 *The Commission recommends the introduction of a third category of informal admission for children and adolescents who are admitted under the Mental Health Act 2001 by parental consent.*

Voluntary Admission and Treatment

6.123 Consent to medical treatment has been discussed in chapter 4, with a number of provisional recommendations.¹³³ The Commission does not seek to differentiate between issues of capacity and consent in relation to physical and mental health, therefore the recommendations outlined in chapter 4 are applicable in the context of mental health. To repeat the recommendations in chapter 4:

6.124 *The Commission provisionally recommends that it should be provided in legislation that a person who is 16 years of age is presumed to have capacity to consent to health care and medical treatment. The word presumption in this regard is intended to reflect the presumption in law that a person of 18 years of age has full capacity.*

6.125 Adolescents aged 16 and 17 would be treated as adults under the *Mental Health Act*, with a number of additional safeguards. A person aged 16 or 17 could consent to voluntary admission and treatment. If a person aged 16 or 17 does not have the capacity to consent, his or her parent could not simply consent to admission on their behalf. In such a case, the provisions in relation to involuntary treatment would apply, if suitable. If not, an option to seek direction and authorisation from the court could be used with the external input of an independent advocate.

6.126 *The Commission invites submissions regarding the consent and refusal of a 16 or 17 year old to voluntary admission and treatment under the Mental Health Act 2001.*

6.127 *The Commission provisionally recommends that a person who is 14 years of age but less than 16 years of age could, subject to certain requirements, be regarded as capable of giving consent to health care and medical treatment, provided he or she has the capacity to understand the nature and consequences of the treatment being provided. Such requirements would include:*

- *In the opinion of the medical practitioner, the patient understands the nature and consequences of the proposed treatment*
- *The medical practitioner shall encourage the patient to inform his or her parents or guardians*
- *The medical practitioner must consider the best interests of the patient*

¹³³ 4.112.

- *The medical practitioner shall have due regard to any public health concerns*

These recommendations shall not legalise any health care treatments that are prohibited or shall be prohibited in any other statutory form.

6.128 Children under the age of 16, with the capacity to consent to voluntary admission, could do so. The capacity of the child would have to be assessed in relation to each decision and aspect of treatment. The situation in relation to a child under the age of 16 and refusal of medical treatment is unclear, as outlined in chapter 5¹³⁴. The UK Code of Practice on the amended *Mental Health Act 1983* does not provide a concrete answer, aside from suggesting that consideration be given to whether or not the child satisfies the provisions in relation to informal admission under the 1983 Act.

6.129 It has been suggested that external input would be effective, in tandem with the parents of the child, and the child in question. An independent psychiatrist and an advocate for the child could assess the situation and weigh up the benefits of voluntary admission against the harm of admitting the child against his or her wishes. The child's views and the views of his or her parents would also be taken into account. If voluntary admission is in the best interests of the child, the child could be admitted as an informal patient with a system of regular and automatic review. Similar to the recommendation in relation to 16 and 17 year olds, an option to seek direction and authorisation from the court could be used here.

6.130 Children under 16, who do not have the capacity to consent to voluntary admission, would also benefit from the external approach, described above. By simply relying on parental consent for a child's "voluntary admission, the rights of the child are infringed. Furthermore, this can lead to deterioration in what may be an already fragile parent child relationship. A multi-disciplinary external approach would allow for independent advocacy, and the views of all parties involved would be heard. If admission is in the best interests of the child, the child could be admitted as an informal patient with a system of regular and automatic review, or if the child was suffering from a mental disorder, as an involuntary patient.

6.131 *The Commission invites submissions regarding the consent and refusal of a person who is 14 years of age but less than 16 years of age in the context of voluntary admission and treatment under the Mental Health Act 2001.*

6.132 *The Commission provisionally recommends that it shall be lawful for a health care professional to provide health care and medical treatment to a person who is 12 years of age but less than 14 years of age, provided that the*

¹³⁴ See 5.17.

health care professional has complied with certain requirements. Such requirements would include:

- *It is mandatory for the medical practitioner to notify the parents or guardians of the child and take account of their views*
- *The medical practitioner must take account of the views of the child in question*
- *The medical practitioner must consider the best interests of the patient*
- *The medical practitioner shall have due regard to any public health concerns*

These recommendations shall not legalise any health care treatments that are prohibited or shall be prohibited in any other statutory form.

6.133 As outlined in chapter 4, this recommendation does not recognise the capacity of children aged between 12 and 14. This recommendation is aimed at ensuring that children have access to necessary health care, and doctors are not prevented from treating children who are genuinely in need of advice and treatment. Applying this to mental health issues, treatment for addictions and counselling would most likely be viewed as necessary treatments. Children as young as 13 have availed of addiction services. Alcoholism is a huge problem in Irish society, and children who become addicted to alcohol from an early age often do not have adequate support from parents and family, particularly if there is a family history of alcohol abuse.

Involuntary Admission and Treatment

6.134 Looking at involuntary admission and treatment under the *Mental Health Act*, to repeat, safeguards are needed. As discussed above, a Tribunal system is favoured over the court setting to review the admission and review of children and adolescents.

6.135 *The Commission provisionally recommends that a Mental Health Tribunal (with an age appropriate focus) rather than the District Court should review the admission and treatment of children and young people as involuntary patients for the purposes of the Mental Health Act 2001.*

6.136 The time limits in relation to review of admission must be improved. In comparison to the system of admission and review of adults detained involuntarily, the system for children is greatly lacking. Under section 25, a child can be detained for an initial 21 day period of admission, and a subsequent 3 months, upon application of the HSE. The District Court can extend the detention by subsequent 6 month periods, upon application of the HSE and a report by a consultant psychiatrist. This is not in tandem with the spirit and

ethos of the *Mental Health Act 2001*, which was enacted to guarantee an independent and automatic system of review to ensure compliance with human rights obligations.

6.137 Looking at the comparable situation for adults, the involuntary admission of an adult is valid for 21 days, and can be renewed by a consultant psychiatrist for subsequent periods of 3 and 6 months. Upon making an admission or renewal order, the consultant psychiatrist must, within a 24 hour period, send a copy of the order to the Mental Health Commission and give notice in writing to the patient. Section 16 (2) sets out the contents of the notice, which must include a description of proposed treatment, and the patient's entitlement to legal representation, the right to communicate with the Inspector and the right to have his or her detention reviewed. The Mental Health Commission, upon receipt of the order, must take various steps outlined in section 17, including referral to the Tribunal, further examination of the patient and engagement of a legal representative for the patient. Section 18 states that the Tribunal must review the detention of the patient no later than 21 days after the admission or renewal order¹³⁵.

6.138 The preceding paragraphs highlight the difference between the safeguards available to adults detained involuntarily, and children detained under section 25. The time frame in relation to the involuntary admission of children must be addressed, with an introduction of a system of regular and automatic review.

6.139 A requirement to obtain a second opinion of an independent consultant psychiatrist for admission and renewal orders coupled with an automatic system of review would increase the protections available to children admitted as involuntary patients.

6.140 *The Commission invites submissions on the most appropriate time limits to use in relation to the review of children and adolescents admitted as involuntary or informal patients under the Mental Health Act 2001.*

6.141 In relation to treatment for children and adolescents who are involuntary patients under the *Mental Health Act*, it is clear that section 61 is not

¹³⁵ Subject to subsection 17(4) of the *Mental Health Act 2001* "the period referred to in subsection (2) may be extended by order by the tribunal concerned(either of its own motion or at the request of the patient concerned) for a further period of 14 days and thereafter may be further extended by it by order for a period of 14 days on the application of the patient if the tribunal is satisfied that it is in the interest of the patient and the relevant admission order, or as the case may be, renewal order, shall continue in force until the date of expiration of the order made under this subsection.

adequate. The three month period which passes before medication is approved under section 61 is excessive and should be reduced. A requirement to discuss the proposed treatment with the child or adolescent would strengthen the rights of the patient. Also, the patient should have an opportunity to participate in the drawing up of an individualised treatment plan.

6.142 Upon consideration of *Storck v Germany*,¹³⁶ the UK Parliamentary Joint Committee on Human Rights stated that the positive obligation under Art 8 of the ECHR requires effective supervision and review of decisions to treat against an individual's will, and that the direction of the responsible clinician, even if that person is a medical practitioner, is not sufficient to provide such supervision and review.

6.143 *The Commission invites submissions on the administration of treatment to children and adolescents admitted as involuntary patients under the Mental Health Act 2001.*

¹³⁶ (2005) 43 EHRR 96.

CHAPTER 7 SUMMARY OF PROVISIONAL RECOMMENDATIONS

The Commission's provisional recommendations in this Consultation Paper may be summarised as follows:

7.01 The Commission provisionally recommends that, in the context of determining the scope of consent to medical care and treatment, a broad definition of health care and medical treatment should be used to encompass diagnosis and treatment and invites submissions on the precise form of this definition. [Paragraph 3.30]

7.02 The Commission provisionally recommends that, in the context of health care provision, the law should respect the evolving capacity of individuals under the age of 17, with the aim of promoting access to necessary medical treatment. [Paragraph 3.131]

7.03 The Commission provisionally recommends that, when treating children, health care professionals grant children an opportunity to express their views and give their views due weight, in accordance with the child's age and maturity. [Paragraph 4.115]

7.04 The Commission provisionally recommends that it should be provided in legislation that a person who is 16 years of age is presumed to have capacity to consent to health care and medical treatment. The word presumption in this regard is intended to reflect the presumption in law that a person of 18 years has full capacity. [Paragraph 4.119]

7.05 The Commission provisionally recommends that a person who is 14 years of age but less than 16 years of age could, subject to certain requirements, be regarded as capable of giving consent to health care and medical treatment, provided he or she has the capacity to understand the nature and consequences of the treatment being provided. Such requirements would include:

- In the opinion of the medical practitioner, the patient understands the nature and consequences of the proposed treatment

- The medical practitioner shall encourage the patient to inform his or her parents or guardians
- The medical practitioner must consider the best interests of the patient.
- The medical practitioner shall have due regard to any public health concerns

These recommendations shall not legalise any health care treatments that are prohibited or shall be prohibited in any other statutory form. [Paragraph 4.127]

7.06 The Commission provisionally recommends that it shall be lawful for a health care professional to provide health care and medical treatment to a person who is 12 years of age but less than 14 years of age, provided that the health care professional has complied with certain requirements. Such requirements would include:

- It is mandatory for the medical practitioner to notify the parents or guardians of the child and take account of their views
- The medical practitioner must take account of the views of the child in question
- The medical practitioner must consider the best interests of the patient.
- The medical practitioner shall have due regard to any public health concerns

These recommendations shall not legalise any health care treatments that are prohibited or shall be prohibited in any other statutory form. [Paragraph 4.128]

7.07 The Commission recommends that it should be provided in legislation that a person who is 16 years of age is presumed to have capacity to consent and refuse health care and medical treatment. The word presumption in this regard is intended to reflect the presumption in law that a person of 18 years of age has full capacity. [Paragraph 5.147]

7.08 The Commission provisionally recommends that, in the context of refusal of life sustaining treatment a person who is 16 years of age may make an application to the High Court to have his or her purported refusal appraised. [Paragraph 5.150]

7.09 The Commission invites submissions on the refusal of life sustaining treatment by a person aged 16 years or older. [Paragraph 5.151]

7.10 The Commission provisionally recommends that a person who is 14 years of age but less than 16 years of age could, subject to certain requirements, be regarded as capable of giving consent and refusal to health

care and medical treatment, provided he or she has the capacity to understand the nature and consequences of the treatment being provided. Such requirements would include:

- In the opinion of the medical practitioner, the patient understands the nature and consequences of the proposed treatment
- The medical practitioner shall encourage the patient to inform his or her parents or guardians
- The medical practitioner must consider the best interests of the patient.
- The medical practitioner shall have due regard to any public health concerns [Paragraph 5.153]

7.11 The Commission invites submissions on the refusal of treatment by a person aged 14 years but less than 16 years. [Paragraph 5.154]

7.12 The Commission provisionally recommends that children aged 12 years of age but less than 14 years of age may not be regarded as capable of refusing medical treatment. [Paragraph 5.157]

7.13 The Commission provisionally recommends that it should be provided in legislation that a person who is 16 years of age is presumed to have capacity to make an advance care directive. The word presumption in this regard is to reflect the presumption in law that a person of 18 years has full capacity. [Paragraph 5.166]

7.14 The Commission provisionally recommends that the Mental Health Act 2001 be amended, with a separate section for people under the age of 18 and invites submissions on the form and content of guiding principles.[Paragraph 6.117]

7.15 The Commission recommends that all children and adolescents admitted and treated under the Mental Health Act 2001 should have access to an independent advocate. [Paragraph 6.119]

7.16 The Commission recommends the introduction of a third category of informal admission for children and adolescents who are admitted under the Mental Health Act 2001 by parental consent. [Paragraph 6.122]

7.17 The Commission provisionally recommends that it should be provided in legislation that a person who is 16 years of age is presumed to have capacity to consent to health care and medical treatment. The word presumption in this regard is intended to reflect the presumption in law that a person of 18 years of age has full capacity. [Paragraph 6.124]

7.18 The Commission invites submissions regarding the consent and refusal of a 16 or 17 year old to voluntary admission and treatment under the Mental Health Act 2001. [Paragraph 6.126]

7.19 The Commission provisionally recommends that a person who is 14 years of age but less than 16 years of age could, subject to certain requirements, be regarded as capable of giving consent to health care and medical treatment, provided he or she has the capacity to understand the nature and consequences of the treatment being provided. Such requirements would include:

- In the opinion of the medical practitioner, the patient understands the nature and consequences of the proposed treatment
- The medical practitioner shall encourage the patient to inform his or her parents or guardians
- The medical practitioner must consider the best interests of the patient
- The medical practitioner shall have due regard to any public health concerns

These recommendations shall not legalise any health care treatments that are prohibited or shall be prohibited in any other statutory form. [Paragraph 6.127]

7.20 The Commission invites submissions regarding the consent and refusal of a person who is 14 years of age but less than 16 years of age in the context of voluntary admission and treatment under the Mental Health Act 2001. [Paragraph 6.131]

7.21 The Commission provisionally recommends that it shall be lawful for a healthcare professional to provide healthcare and medical treatment to a person who is 12 years of age but less than 14 years of age, provided that the healthcare professional has complied with certain requirements. Such requirements would include:

- It is mandatory for the medical practitioner to notify the parents or guardians of the child and take account of their views
- The medical practitioner must take account of the views of the child in question
- The medical practitioner must consider the best interests of the patient
- The medical practitioner shall have due regard to any public health concerns

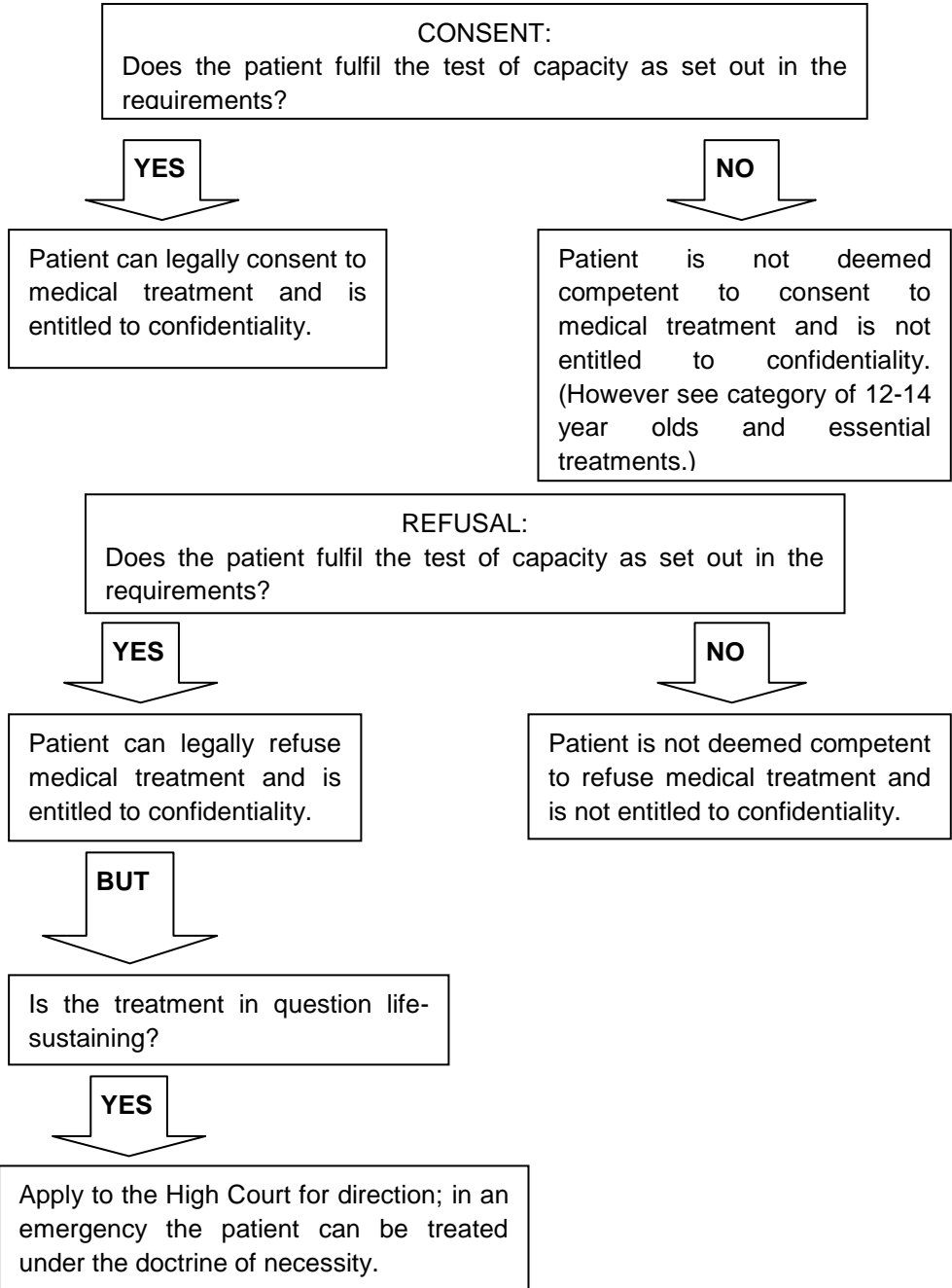
These recommendations shall not legalise any health care treatments that are prohibited or shall be prohibited in any other statutory form. [Paragraph 6.132]

7.22 The Commission provisionally recommends that a Mental Health Tribunal (with an age appropriate focus) rather than the District Court should review the admission and treatment of children and young people as involuntary patients for the purposes of the Mental Health Act 2001. [Paragraph 6.135]

7.23 The Commission invites submissions on the most appropriate time limits to use in relation to the review of children and adolescents admitted as involuntary or informal patients under the Mental Health Act 2001. [Paragraph 6.140]

7.24 The Commission invites submissions on the administration of treatment to children and adolescents admitted as involuntary patients under the Mental Health Act 2001. [Paragraph 6.143]

CONSENT AND REFUSAL 14-16



CONSENT AND REFUSAL 12-14

CONSENT:

There is no presumption of capacity and the parents of the child must be notified. A medical practitioner can however treat the patient, if the requirements are fulfilled.

REFUSAL:

A child aged 12-14 is not deemed competent to refuse medical treatment.